NATIONAL ACTION PLAN FAMILY PLANNING SERVICES

2014-2015

DIREKTORAT JENDERAL BINA GIZI DAN KESEHATAN IBU DAN ANAK
2013

PREFACE

This National Action Plan for Family Planning Services for 2014 - 2015 has been successfully prepared in close collaboration with BKKBN, other programs, sectors, professional organizations, non-governmental organizations, experts and donor agencies associated with the strengthening of family planning services in Indonesia.

Improving maternal health by reducing the maternal mortality rate (MMR) by ensuring that childbirth is attended by health personnel is Goal 5a of MDGs we all seek to achieve. In addition to birth attendance by health personnel, another effort which supports the improvement of maternal health is the provision of increased universal access to reproductive health as \contained in Goal 5b. This includes active participation in family planning or Contraceptive Prevalence Rate (CPR), antenatal coverage which meets the standard, teen birth rate or Age Specific Fertility Rate (ASFR) and unmet need. In order to achieve Goal 5 of MDGs, it is necessary to carry out some acceleration efforts to achieve the goal, one of which is the preparation of the National Action Plan for Family Planning Services for 2014-2015 in collaboration with BKKBN and other relevant programs and sectors.

This book contains the acceleration efforts for the achievement of targets of family planning services, situation analysis of family planning services, the National Action Plan for Family Planning Services as well as its monitoring and evaluation. The publication of this book is expected to provide a clear direction for the organizers of the family planning program at the national and local levels. I would like to thank all parties who have contributed to the preparation of this National Action Plan, BKKBN, consultants in the writing of this Action Plan as well as other relevant programs and sectors. We also welcome any inputs and valuable suggestions for future improvement of this National Action Plan.

Jakarta, 23 December 2013
Acting Director General of Nutrition and MCH
Ministry of Health

Prof. Dr. dr. Akmal Taher, SpU (K)

MENTERI KESEHATAN
REPUBLIK INDONESIA

REMARK BY
MINISTER OF HEALTH OF THE REPUBLIC OF INDONESIA

The IDHS 2012 data shows that the Maternal Mortality Rate (MMR) remained high at 359 per 100,000 live births. The high rate of cases of 4 Too's (too young, too old, too close together and too many children born) is one of the factors that significantly contributes to the increasing maternal mortality rate.

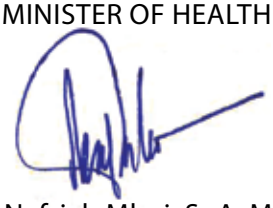
Strengthening family planning services is one of the important efforts which supports the acceleration in the reduction of maternal mortality rate by preventing unwanted pregnancies and pregnancies in the state of 4 Too's. The data indicates that the scope of the active participation in family planning or Contraceptive Prevalence Rate (CPR) only increased by 0.5% from 57.4% (2012 IDHS) to 57.9%, the unmet need only decreased by 0.6% from 9.1% (2007 IDHS) to 8.5% (2012 IDHS) and teen birth rate or Age Specific Fertility Rate (ASFR) of those aged 15-19 years was still high at 48/1000 among women aged 15-19 years. Less optimal achievement of these indicators contributes to the stagnant Total Fertility Rate (TFR) and ultimately resulted in the high maternal mortality rate in Indonesia.

Intervention efforts in the strengthening of family planning has been carried out through the provision of education on reproductive health for adolescents, counseling and family planning services for brides-to-be and couples of reproductive age. The groundbreaking effort in accelerating the decline in Maternal Mortality Rate is contained in the National Action Plan for Family Planning Services for 2014 -2015. The action plan is prepared together with BKKBN, academia, professional organizations, other programs and sectors.

I would like express my highest appreciation to all parties who have been involved in the preparation and publication of this National Action Plan for Family Planning Services the 2014-2015. I hope that this action plan can be useful for those implementing the family planning program at the central and local levels, government institutions, private sector, and all relevant parties in the implementing of this program.

I hope that our efforts to reduce the Maternal Mortality Rate and Total Fertility Rate in order to improve maternal health and public health of Indonesian people will optimally achieve the targets.

Jakarta, December 2013
MINISTER OF HEALTH



dr. Nafsiah Mboi, SpA, MPH

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LIST OF ABBREVIATIONS

IUD	Intra Uterine Device
MMR	Maternal Mortality Rate
Contraceptive	Contraceptive Commodities
ASFR	Age Specific Fertility Rate
Bappenas	National Development Planning Agency
BKIA	Maternal and Child Health Center
BPJS	Social Security Implementing Agency
BPS	Statistics Indonesia
CPR	Contraceptive Prevalence Rate
DTPK	Isolated Areas, Border Areas and Islands
PIH	Pregnancy-Induced Hypertension
Jampersal	Maternity Insurance
JKN	National Health Insurance
KKB	Population and Family Planning
IEC	Information, Education and Communication,
PGR	Population Growth Rate
MDGs	Millennium Development Goals
MKJP	Long-Acting Contraceptive Methods
MOP	Male Surgical Method
MOW	Female Surgical Method
NRR	Net Reproductive Rate
Riskesdas	Basic Health Research
Risfaskes	HealthFacilities Research
P4K	Complication Prevention and Delivery Planning Program
PKPR	Youth Friendly Health Services
PKRT	Integrated Reproductive Health Services
Polindes	Village Birth Facility/ Maternity Hut
PPB	Postpartum Bleeding
RS	Hospital
RSB	Maternity Hospital
Posyandu	Maternal and Child Health Center
CRA	Couple of Reproductive Age
Puskesmas	Community Health Center
Pustu	Auxiliary Community Health Center
PUP	Increasing the Age of Marriage
RPJMN	National Medium-term Development Plan
RPJPN	National Long-term Development Plan
SD	Elementary School
IDHS	Indonesian Demographic and Health Survey
HR	Human Resources
SJSN	National Social Security System
SMA	High School
SMP	Junior High School
PC	Population Census
TFR	Total Fertility Rate
TNI	Indonesian National Army

LIST OF TERMINOLOGY

Age Specific Fertility Rate [ASFR]	The number of births by age of women in certain age groups (i.e., 15-49 years)
Maternal Mortality Rate [MMR]	The death of a woman during pregnancy up to 42 days after the end of her pregnancy, irrespective of the duration and place of pregnancy, which is caused by or triggered by the pregnancy itself or handling of pregnancy, but not due to accidents
Contraceptive Prevalence Rate [CPR]	The rate which indicates the number of couples of reproductive age that use contraceptive methods at the time the enumeration is conducted compared to all couples of reproductive age.
Unmet need	The proportion of women of reproductive age who are married or cohabitate (sexually active) and do not want any more children or want to space their pregnancies but are not using any contraceptive methods
Net Reproductive Rate (NRR)	The average number of daughters born to a woman during her lifetime and will continue to live up to replace the position of her mother.

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CHAPTER 1 : INTRODUCTION

1.1. Background

Improving maternal health is part of the development agenda of the Millennium Development Goals (MDGs). The target 5.a. of MDGs states the goal to reduce the maternal mortality rate (MMR) by three quarters between 1990 and 2015. In the meantime, the target 5.b. is to achieve universal access to reproductive health services by 2015. There are four parameters that are used to assess access to reproductive health services, namely Contraceptive Prevalence Rate (CPR), Adolescent Birth Rate for girls aged 15-19 (Age Specific Fertility Rate, ASFR offemale adolescents aged 15-19 years), Antenatal Care Coverage, and unmet need.

To meet the international commitment to achieve the targets of MDGs by 2015, the Government of the Republic of Indonesia plan and implement the development gradually and continuously as outlined in the 2010-2014 Medium-Term Development Plan (RPJMN). The 2012 Indonesia Demographic and Health Survey (IDHS) date shows that the outcomes of the development that have been achieved are still relatively far from the targets as set in the targets of RPJMN for 2010-2014 and targets of MDGs by 2015.

The following table presents the targets in the development of maternal health and results achieved until 2012. With the remaining 2 years, special efforts are needed to achieve the targets the MDGs by 2015.

Table 1.1
Targets and Achievements of the Development of the Maternal Health Sector in Indonesia

Indicator	Baseline in 1991	Target of 2014 RPJMN	Target of MDGs by 2015	Achievement by 2012
5.1. MMR (per 100,000 live births)	390	118	102	359 (2012IDHS)
5.2. Birth attendance by trained health workers	40.70%	90%	90%	83.1% (2012IDHS)
5.3.a. CPR of married women aged 15-49, at this time, all methods	49.7%	-	66%	61.9% (2012IDHS)
5.3.b. CPR of married women aged 15-49 years, at this time, modern methods	47.0%	60.1%**)	65%	57.9% (2012 IDHS)
5.4. ASFR *) of girls aged 15-19 years (per 1,000 girls aged 15-19 years)	67	30	30	48 (2012 IDHS)

5.5. Antenatal service coverage				
• **1 visit**	75%	95%	95%	95.7% (2012 IDHS)
• **4 visits**	56 %	90%	90 %	73.5% (2012 IDHS)
5.6 Unmet need	12.7%	6.5% **)	5%	8.5% (2012IDHS)

Notes:

*) ASFR = Age Specific Fertility Rate

**) The target has been adjusted upon agreement of the Ministry of Finance, Bappenas and BKKBN

MMR is an indicator of the impact of various initiatives aimed at improving maternal health. Maternal deaths will not occur without pregnancy. As a result, pregnancy is a proxy for a determinant of maternal mortality, in addition to complications in pregnancy and childbirth. To decrease the incidence of maternal mortality, pregnancy should be managed in such a way that it does not occur in conditions with high risk of complications. Pregnancy, for example, should not occur in a state of "4 Too's", -- too young, too close together, too many, and too old. In this context, the Population and Family Planning Program (KKB Program) and in particular theFamily Planning Services have an important role.Of the 6 indicators of maternal health which are made the targets of 2010-2014 RPJMN and MDGs by 2015, two of which are related to family planning services, CPR and unmet need. The result of 2012 IDHS shows that the achievement of the indicators is still lower than expected.

A lot of things may be the reasons why the achievement of family planning services has not been as expected. One is them is the reduced number of family planning field officers, causing the coaching for participation in family planning to be limited, unequal coverage of provision of family planning services, and less optimal quality of family planning services. Advocacy activities to provide understanding of the importance of family planning to various stakeholders have not generated a strong commitment to support the delivery of family planning services. In addition, the Information, Education, andCommunication (IEC) activities carried out in the community have not been able to change the value with regard to the ideal number of children desired and the behavior of the public in obtaining contraceptive services.

The weakening of the organizational structure and the decreasing availability of resources for KKB Program in the region may result in the decreased performance of KKB. Advocacy, IEC and counseling activities are not implemented as they should have been, resulting in changes in the value of the public with regard to the ideal number of children, which then leads to decreased demand for family planning services. The weakening of advocacy also has also led to the declining support and participation of the various stakeholders on the provision of family planning services. Some sharp, effective groundbreaking actions should be taken in order to improve this situation. On the one hand, the availability, affordability and quality in the provision of family planning services need to be improved, while on the other hand, the demand for family planning services also needs to be improved.

In 2014 the National Health Insurance (JKN) will be implemented as the fulfillment of the mandate of Law of the Republic of Indonesia Number 40 of 2004 on the National Social Security System (SJSN). The Presidential Regulation No. 12 of 2013 on Health Insurance states that the benefits of promotive and preventive health care include the provision of individual counseling services, basic immunizations, family planning and health screening. It is also stated that family planning services which are covered include counseling, basic contraception, vasectomy and tubectomy. The service is delivered in collaboration with the agency in charge of family planning. With reference to the Minister Regulation Number 71 of 2013 on health care service in the National Health Insurance, health care providers including all health facilities in collaboration with the Health BPJS in the form of first-level health facilities and advanced level referral health facilities.

The National Action Plan for Family Planning Services for 2014-2015 is prepared in order to provide direction and foundation for the development of a wide range of efforts aimed at the strengthening of providers or organizers and users of family planning services. The National Action Plan is prepared in line with the Action Plan for the Acceleration inReduction of Maternal Mortality Rate in Indonesia.The action plan is expected to strengthen the cooperation across programs and across sectors in support of family planning services. Furthermore, the National Action Plan is expected to accelerate the achievement of the targets of MDGs, namely the reduction in MMR and the provision of universal access to reproductive health services.

1.2. Objectives

General Objective

The National Action Plan for Family Planning Services is prepared as a reference for the strengthening of family planning services to support the efforts to accelerate achievement of the MDGs, improve maternal health and increase universal access to reproductive health services.

Specific Objectives

1. Availability of a reference for development and implementation of a range of activities to accelerate the achievement of targets of family planning services.
2. Availability of advocacy materials to gain support from various stakeholders.
3. Synergy of activities implemented by various stakeholders in strengthening family planning services.

1.3. Legal Foundation

The following are laws and regulations which are made the bases for the implementation of KKB Program and the delivery of family planning services at various administrative levels:

1. Law of the Republic of Indonesia Number 24 of 2011 on the Social Security Organizing Agency;
2. Law of the Republic of Indonesia Number 36 of 2009 on Health;
3. Law of the Republic of Indonesia Number 52 of 2009 on Population Development and Family Development;
4. Law of the Republic of Indonesia Number 17 of 2007 on the 2005-2025 National Long Term Development Plan;
5. Law of the Republic of Indonesia Number 40 of 2004 the National Social Security System;
6. Law of the Republic of Indonesia Number 33 of 2004 on the Financial Balance between the Central Government and the Local Government;
7. Law of the Republic of Indonesia Number 32 of 2004 on the Local Government;
8. Law of the Republic of Indonesia Number 29 of 2004 on Medical Practice;
9. Law of the Republic of Indonesia Number 23 of 2002 on Child Protection;
10. Presidential Regulation Number 12 of 2013 on Health Insurance;
11. Presidential Regulation Number 72 of 2012 on the National Health System;
12. Presidential Regulation Number 5 of 2010 on the National Medium Term Development Plan;
13. Government Regulation of the Republic of Indonesia Number 38 of 2007 on the Distribution of Government Affairs among the Central Government, Provincial Government and District / City Government;
14. Presidential Instruction Number 2A of 2012 on the Strategies and Activities in the Effort to Accelerate the Reduction of Maternal Mortality Rate;

15. Presidential Instruction Number 2A of 2011 on the Achievement of Targets of Millennium Development Goals;
16. Regulation of Minister of Health Number 71 of 2013 on Health Care Service in the National Health Insurance;
17. Regulation of Minister of Health Number 6 of 2013 on the Criteria of Health Care Facilities;
18. Regulation of Head of BKKBN Number 249/PER/E1/2011 Policy on Provision of Contraceptive Devices and Drugs in Population and Family Planning Programs;
19. Decree of Minister of Health Number 1464/Menkes/Per/X/2010on the Licensing and Organizing of Midwifery Practice;
20. Decree of Minister of Health Number 758/Menkes/SK/IV/2011 on the Establishment of Districts, Subdistrict and Puskesmas in the Border Areas and Small Inhabited Outlying Islands which are the Priority Targets of the National Health Service Program in DTPK for FY 2010-2014;
21. Decree of Minister of Health Number HK. 03.01/160/I/2010the 2010-2014 Strategic Plan;
22. Decree of Minister of Health Number 128/Menkes/SK/II/2004 on Basic Policy on Puskesmas (Community Health Center);
23. Regulation of Head of National Family Planning Coordinating Agency Number 143/HK-010/B5/2009 on the Guidelines for Security and Family Planning Services.

1.4. Goals

The National Action Plan is a document that can be used by various stakeholders to develop activities in support of the family planning services. The following are the parties that are expected to use this document:

1. Ministries and institutions at the national level which have interest in family planning services.
2. Institutions at the provincial and district/city levels which have interest in family planning services.
3. Non-governmental agencies and organizations both at the central and local levels which have interest in family planning services.
4. Civil Society Organizations both at central and local levels which have interest in family planning services.
5. International, national and local development partners, at the provincial and district / city levels.

CHAPTER 2 : THE POLICY TO ACCELERATE ACHIEVEMENT OF TARGETS OF FAMILY PLANNING SERVICES

2.1. Concept of Family Planning Service

2.1.1.Objective of Population and Family Planning Programs

Equitable distribution ofquality family planning services has a strategic role as part of a comprehensive effort to reduce MMR and as part of the KKB Program. Article 78 of Law of the Republic of Indonesia Number 36 of 2009 on Health states that health services in family planning is intended to plan pregnancy for couples of reproductive age in order to develop healthy and intelligent generation and that the government is responsible for and guarantees the availability of personnel, facilities for services, devices and drugs in the provision of quality family planning services which are safe and affordable for the community.

In line with the provisions of the Law Number 36 of 2009 on Health, Law Number 52 Year 2009 on the Population Development and Family Development Article 1 states that family planning is an effort to plan the number of children, determine intervals between pregnancies and ideal age range for pregnancy, through the promotion, protection and assistance given in accordance with the reproductive rights to create quality families. It is also stated that the husband and wife have equal position, rights and obligations in participating in family planning and the government must provide assistance for the husband and wife with regard to the contraceptive methods or drugs.

2.1.2.Life Cycle Approach and Principle of Continuum of Care

Family planning service is part of the implementation of the life cycle approach and the principle of continuum of care to improve maternal and child health. Increased access to quality maternal and child health should be provided for female adolescents, women of reproductive age, during the periods of pre-pregnancy, pregnancy, childbirth and post childbirth, and for babies and under-five children
Family planning service is one of individual promotive and preventive health efforts. The implementation of the life cycle approach and the principle of continuum of care in family planning service can be seen from the type of service and the goals to be achieved. Family planning service should be provided since adolescents. The service is in the form of information about reproductive health which is integrated in

the Adolescent Friendly Health Services (PKPR).For those who will soon get married, the service provided is in the form of information as part of reproductive health services. The service for pregnant women is integrated into the maternal antenatal services in the form of counseling of post-childbirth family planning, use of KIA Book (Maternal and Child Health Book), Childbirth Planning and Complications Prevention Program (P4K), as well as the provision of information in Pregnant Women Class. If after giving birth, a woman is not using any contraception, during the provision of post-childbirth service, the health workers can provide post- childbirth family planning counseling and the postpartum family planning service. For couples of reproductiveage who are pregnant, family planning service is given in the form of counseling and family planning service for the purposes of planning and spacing pregnancies.

Upon observation of various problems prevalent among the adolescents, including risky behaviors which contribute to the incidence of maternal mortality, the Ministry of Health develops the Adolescent Health Program using the approach of Adolescent Friendly Health Services (PKPR). This approach was first introduced in Indonesia in 2003, and until the end of 2012 it is reported that 3191 Puskesmas have been able to provide PKPR. Of 497 districts / cities in Indonesia, 386 (77.67%) have at least 4 Puskesmas which can provide PKPR. This Puskesmas organizes comprehensive services for adolescents that include(1) adolescent reproductive health services; (2) nutrition services; (3) adolescent mental health services; (4) prevention and handling of abuse of drugs, psychotropic and addictive substances, (5) the detection and management of violence against adolescents; and (6) the detection and management of tuberculosis. Efforts to increase the age of marriage and improve their knowledge about reproductive health which are aimed to lower ASFR for the age of 15-19 years are conducted in an integrated manner with PKPR.

2.1.3.Development of Family Planning Services

The 2010-2014 Strategic Plan of the Ministry of Health states that the vision of the Ministry is to create healthy, independent and fair community. To create this vision a number of missions have been set: (1) to improve public health through community empowerment, including empowerment of the private sector and civil society; (2) to protect public health by assuring the sustainability of comprehensive, equally distributed, quality and fair efforts to improve health; (3) to ensure the availability and equitable distribution of health resources; and (4) to realize good governance. To realize those missions, the Ministry of Health has developed some strategies as follows:

1. Increasing the empowerment of community, private sector and civil society in the development of health sector through the national and global cooperation.
2. Providing quality, evidence-based health service which is increasingly affordable, fair, and equally distributed; with the priority placed on promotive and preventive efforts.
3. Increasing financing in the development of health sector, especially to create a national social health security.
4. Improving the development and empowerment of equally distributed and quality health human resources.
5. Increasing the availability, distribution, and affordability of medicines and medical equipment as well as ensuring the safety, effectiveness, usefulness and quality of pharmaceutical supplies, medical equipment, and food.
6. Increasing the health management which is accountable, transparent, effective and efficient to strengthen the accountabilityof decentralized health management.

Puskesmas (Community Health Centre) is a basic health care facility available in every subdistrict in Indonesia. The strategies of the Ministry of Health are implemented by the establishment of 6 Compulsory Health Efforts of Puskesmas which include Health Promotion, Environmental Health, Maternal and Child Health and Family Planning, Improvement of Nutrition, Prevention and Eradication of Infectious Disease

and last Medication. Thus, it is clear that family planning service is included in the compulsory health efforts of *Puskesmas*.

In connection with the strategy to accelerate the decrease in MMR, the Ministry of Health has established 9 provinces with the highest population as the focus of the program, namely North Sumatra, South Sumatra, Lampung, Banten, DKI Jakarta, West Java, Central Java, East Java and South Sulawesi. These provinces are also part of the 10 main buffer provinces in the intensification of the development of family planning set by the National Population and Family Planning Agency (BKKBN). The other province is East Nusa Tenggara.

The implementation of family planning service is part of the National Health System (SKN). SKN is the management of health affairs implemented by all stakeholders in Indonesia in an integrated and mutually supporting manner in order to guarantee the improvement of public health.The management of health is carried out at the national and local levels by taking into account the local autonomy and the autonomous functions at the local levels in the health sector. As part of SKN, family planning service is also organized at various administrative levels. Furthermore, family planning service has the emphasize on improving the behavior and independence of the community, the professionalism of health human resources , and promotive and preventive efforts without neglecting the curative and rehabilitative efforts.

2.2. Targets

The following table represents the national targets set on family planning service, both the targets of the 2010-2014 RPJMN and those of MDGs by 2015.

Table 2.1
National Targetswith regard to Family Planning Services

Indicators ofimpacts and outputs of	Baseline in 1991	Target of 2014 RPJMN
TFR	2.36 *)	2.11
ASFR of age group of 15-19 years (per 1000 female adolescents aged 15-19 years)	30	30
CPR of modern contraceptive methods	60.1% *)	65%
Unmet need	6.5% *)	5%

*) Target shave been adjusted to the agreement of the Ministry of Finance, Bapenasand BKKBN

CHAPTER 3 : SITUATION ANALYSIS OF FAMILY PLANNING SERVICES

3.1. Conceptual Framework of Situation Analysis

The preparation of the National Action Plan requires a sharp analysis in order that the root of the problem can be identified including the strengths and weaknesses. There are a number of theories that can be used to describe the relationship between different variables which are expected to influence the health-care coverage. However, the theory used in the situation analysis of the preparation of the National Action Plan on Family Planning Service is the one developed by Philips and Morrison (1998). The following figure presents a conceptual framework of the situation analysis.

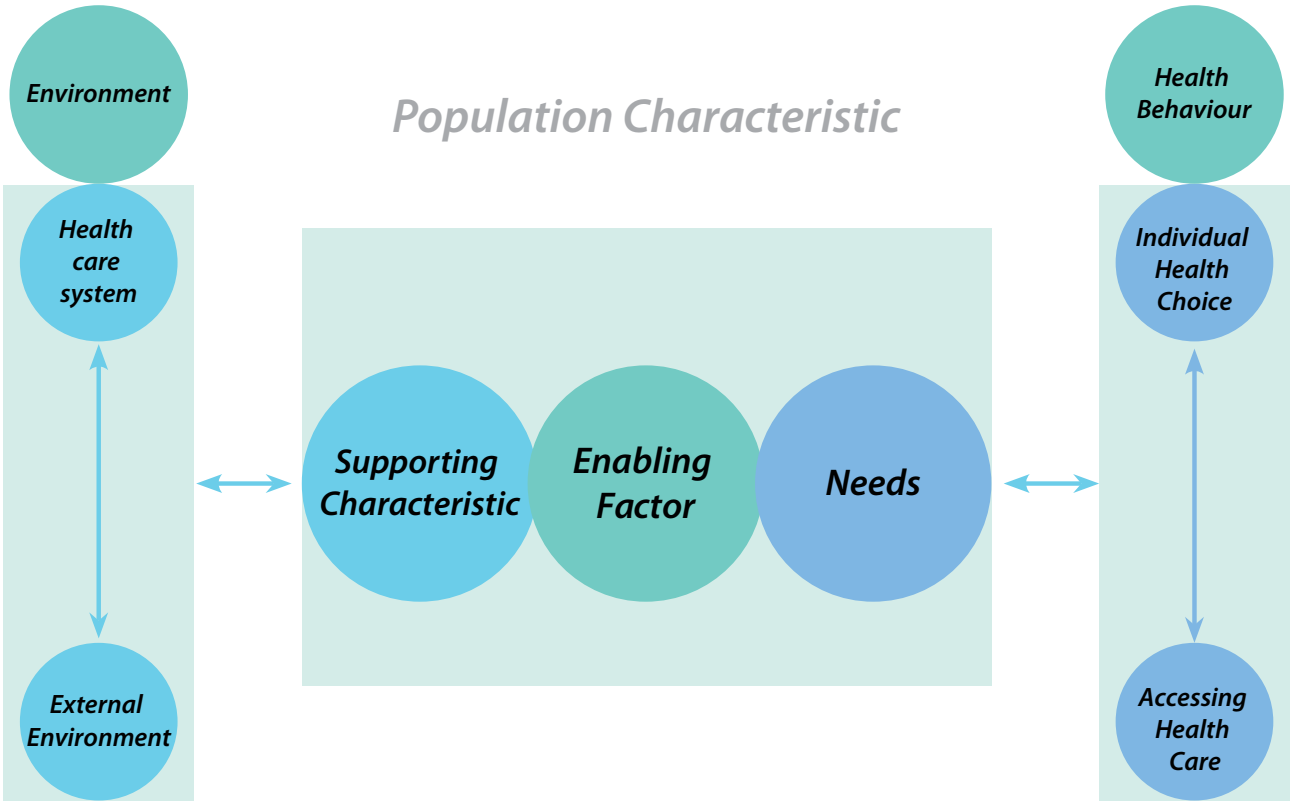


Figure 3.1
Conceptual Framework of Situation Analysis

This conceptual framework describes some of the factors that influence the utilization of health services, namely (1) the environmental factors which in details observe the relationship between health-care system and its external environment, and (2) the characteristics of the population which include the predisposing factors, enabling factors and needs. These factors will influence the patterns of health behavior from individual health choice and use of health services. The three interconnected groups of variables will have on impact on the degree of health, which is reflected among other things on the level of morbidity and mortality.

In the following situation analysis of family planning services, the impacts of two indicators namely MMR and TFR are analyzed. Other indicators are unwanted pregnancy and ASFR of girls aged 15-19 years. The external environmental factors are the implementation of JKN, planning system, procurement and distribution of logistics, and system of planning and empowerment of health workers; in the meantime, included in the health care service system factors are the availability of resources for family planning services, affordability and quality of family planning service.Predisposing characteristics which will be discussed include the size, the growth rate and composition of population, marriage patterns, and population distribution. The enabling factors which will be studied are level of education and knowledge and beliefs, whereas needs which will be studied are the desire to have children and ideal number of children. The analysis of individual health choice will include early marriage, choice of contraceptive methods, and participation of men; whereas the analysis of use of health services will include unmet need, active participant in family planning and interregional disparities.

3.2. Impacts of the National Population and Family Planning Programs

3.2.1.Maternal Mortality Ratio

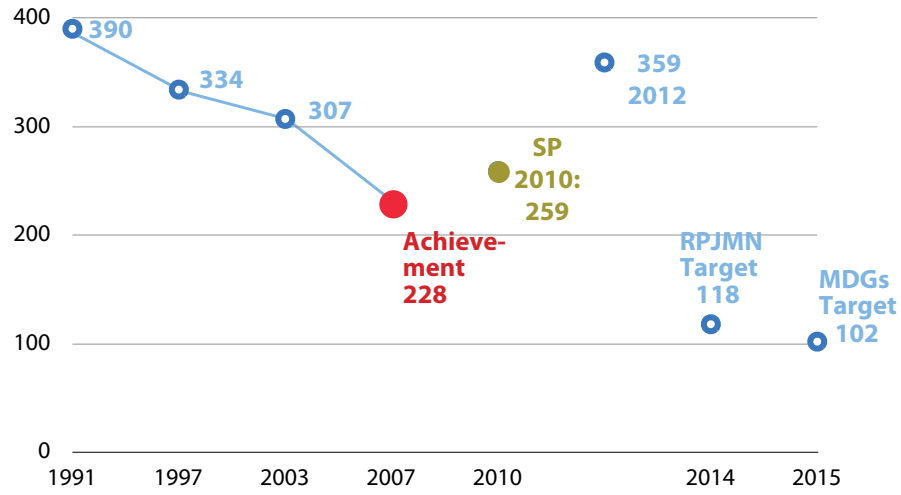


Figure 3.2.
MRR in Indonesia in1990-2012,
Target of 2010-2014 RPJMN and Target of MDGs by 2015

MMR is one of the indicators to assess not only the women's health status but also the level of women's welfare. Reducing maternal mortality rate is one of the targets of MDGs, that is the goal 5. The target is to reduce maternal mortality rate by three quarters from 390 per 100,000 live births in 1991 to 102 per 100,000 live births by 2015. The result of 2012 IDHS show that the MMR was 359 per 100,000 live births, while 2010 Population Census and 2007 IDHS respectively showed that the MMR was 259 per 100,000 live births and 228 per 100,000 live births. This difference may be caused partly because of differences in the sample size of each survey that affects the level of confidence in the measurement results. The sample

size of IDHS is much smaller than that of Population Census, so it has a lower confidence level.Therefore, the point estimate of MMR generated by each survey should be interpreted carefully. Regardless of the varying degrees of confidence in the results of the measurement of MMR according to the surveys that have been conducted, it appears that the MMR achieved so far is still relatively far from the desired targets, both the target of 2010-2014 RPJMN and the target of MDGs. The following figure shows that the MMR in Indonesia in 1990-2012, the target of 2010-2014 RPJMN and the target of MDGs.

Indonesia's high maternal mortality rate is caused by a variety of direct and indirect causes. The main direct causes are hemorrhage, pregnancy-induced hypertension (PIH), and infections. Further analysis of the results of the 2010 Population Census data shows that 32 % of maternal deaths were caused by PIH, followed by puerperal complications at 31% and post-partum bleeding at 20%. Maternal mortality is not only caused directly by complications of pregnancy and childbirth, but also by a variety of diseases such as tuberculosis, anemia, malaria, and heart disease. Pregnancy and childbirth can aggravate these diseases and these diseases can increase the risk of complications of pregnancy and childbirth. The cases of maternal mortality by indirect causes were quite significant in Indonesia, at about 22 %. Therefore, in addition to planning the pregnancy to avoid the health risks, it is necessary to carefully address those various indirect causes.

It is shown in 2012 IDHS that about 95.7% of pregnant women received antenatal care (75% from midwives and 20.4 % from doctors), but only 87.8 % had at least four antenatal visits during pregnancy. Furthermore, only 73.5% had 4 scheduled visits. Basic Health Research in 2010 found that the women who did not receive antenatal care were more likely to give birth at home (86.7%) than those mothers who had 4 antenatal visits (45.2%). The quality of antenatal care is one aspect that needs to be considered because it affects early diagnosis and proper treatment. Riskesdas (Basic HealthResearch) in 2010 also showed that only 45% of pregnant women were informed about the signs of pregnancy complications. In other words, counseling which is an important part of antenatal care has not been implemented well. In fact, one of the most appropriate times to do family planning counseling is during the antenatal period.

Birth attendance in health facilities showed a gradual increase. In 2007 attended births in health facilities represented 46.1% of total births (IDHS, 2007), which increased to 59.4 % in 2010 (Riskesdas 2010). Nevertheless, disparities are still visible between regions, between cities and villages, between different levels of education and between different levels of economics. The highest cases of births in health facilities were found Bali (90.8%), while the lowest in the Southeast Sulawesi (8.4%).The cases of births in health facilities were higher in urban areas (70.3%) than in rural areas (28.9%). Women with low education were more likely to give birth at home (81.4%) than women with higher education levels (28.2%). Women at the lowest quintile group for expenditures were 5 times more likely to give birth at home (84.8%) than those at the highest quintile for expenditure (5.5%).

3.2.2.Total Fertility Rate

TFR represents the average number of children born to a woman when she is between 15 to 49 years old or until the end of her reproductive period. The comparison of TFR between regions can demonstrate level of success in the implementation of socio-economic development by the relevant regions. High TFR reflects the low average of marital age, low education level (particularly among women), lower socioeconomic level or high level of poverty. TFR is also an indicator of the success rate of KKB Program.

The Indonesian Demographic and Health Survey conducted in 2002/2003, 2007 and 2012 indicate a stagnant TFR. In 2012 IDHS it was shown that targeted TFR was at 2.6, higher than the target at 2.1. The TFR was at the same figure as in IDHS 2002/2003 and IDHS 2007. The result of IDHS 2012 also showed that TFR of women in urban areas was 0.4 lower than that of women in rural areas. However, birth rates by age group for the 25-29 years, 30-34 years, and 40-44 years age groups in urban areas were found to be higher than the birth rates in rural areas.

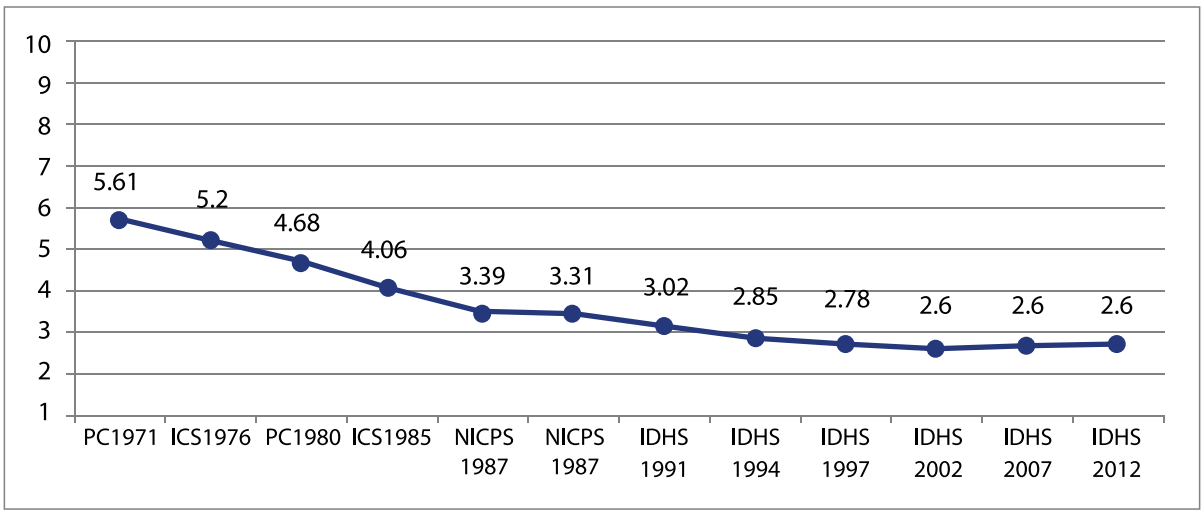


Figure 3.3
Trend of TFR in Indonesia between 1970 and 2012

The following figure shows a wide gap in TFR among various regions in Indonesia. Some provinces attained TFR between 2.1 to 2.42; while others' TFR was between 3.39 and 3.7. Papua, West Papua and some regions in West Sulawesi had TFR> 3.0.

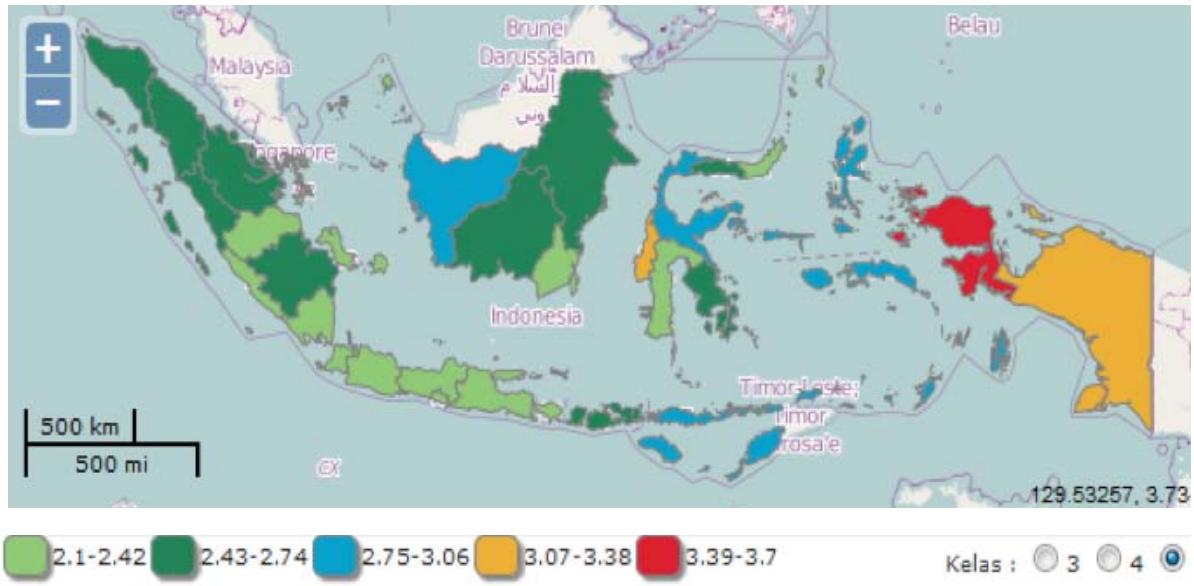


Figure 3.4
TFR Disparity of Different Regions in Indonesia

3.2.3.Unwanted Pregnancies

Unwanted pregnancy is a pregnancy experienced by a woman who does not desire to be pregnant (BKKBN, 2007). The causes of unwanted pregnancy include rape, lack of knowledge about contraceptive methods, having too many children, the fetal health, a woman's age which is still too young or not ready for marriage, not being ready to get married to or relationship with an immature partner, and economic problems (World Health Organization, 2000). In Indonesia the cases of unwanted pregnancy are high. The data of 2007 IDHS showed 17% of cases of unwanted pregnancies occurred among couples of reproductive age.

Unwanted pregnancy due to situations described as "4 Too's" can increase the risk of complications and death in pregnant women. In addition, it will lead to unsafe abortions which contribute to increased maternal mortality. Unwanted pregnancy can have an adverse impact on the health, social and psychological life of the mother and the baby, so not only does it increase maternal morbidity and mortality but it can also make the fetal or the infant have high risk of such as impaired growth and development (Felipe and David, 2001).

Unwanted and mistimed pregnancy can be categorized as an unmet need. The study of unmet need by Prihastutik (2004) on married women aged 15-49 years found that 50% of married women in Indonesia did not want have any more children. The percentage of married women who desire not to have any more children was higher in rural areas (5%) than in urban areas (2.1%). 2012 IDHS found that of all married women, approximately 47% did not want to have any more children, and in fact 3% of them had undergone surgical sterilization.

3.2.4.Adolescents Birth Rate

The 2012 IDHS data shows that ASFR of female adolescents aged 15-19 years reached 48 per 1,000 women aged 15-19 years. This figure is slightly lower than the 2007 IDHS which was 51 per 1,000 women aged 15-19 years. The percentage of female adolescents aged 15-19 years who had given birth in rural areas (13.7%) is higher than the figure in urban areas (7.3%). The number of births to girls aged 15-19 years is also higher among those who do not go to school (13.6%) than those who are still in high school (3.8%).

The high ASFR of girls aged 15-19 years indicates the high rate of early marriage and premarital sex among adolescentsagers. The 2012 IDHS data shows that the median age of the first marriage of girls aged 25-49 years was 20.4 years and the median age of first marriage of women aged 25-49 years once married was 20.1 years. Pregnancies occurring in those who are under 20 years old have a higher health risk for both the mother and the baby. Women who are pregnant at a young age are at a higher risk for bleeding during labor and they are also more likely to give birth to babies with low birth weight.

3.3. Environmental Factors

3.3.1.External Environmental System

Law of the Republic of Indonesia Number 40 of 2004 on the National Social Security System (SJSN) Article 19 states that the health insurance is organized nationally based on the principle of social insurance and the principle of equity. Article 19 paragraph 2 states that health insurance is organized with the purpose of ensuring that participants receive health care benefits and protection to meet the basic health needs. In Presidential Regulation Number 12 of 2013 on Health Insurance it is stated that family planning service is one of the preventive and promotive services. The services of family planning covered include counseling, basic contraception, vasectomy and tubectomy. Family planning services which are covered by JKN are the Individual Health Care (UKP), the insertion and replacement of contraceptive devices, complication services and the consulting services. This Presidential Regulation also regulates the facilities of family planning services, competence of service providers, the availability of free contraceptive methods and support facilities, and the records and reporting systems.

With reference to Regulation of Minister of Health Number 71 of 2013 on Health Care in the National Health Insurance (JKN), health care providers include all health facilities which are in collaboration with Health BPJS in the form of the first-level health facilities and advanced level referral health facilities. The first-level health facilities can be puskesmas (community health center), practice doctors, dental practices, pratama clinics and Class D Pratama Hospitals. With regard to the advanced level referral health facility, the facilities are primary clinics, general hospitals and specialty hospitals.

Drugs and medical devices that have been borne by the Government and / or Local Government are not covered by Health BPJS, including basic contraceptive methods, the procurement of which is done by the health facilities and the supporting facilities that implement JKN using e-purchasing based on e-catalog in accordance with the prevailing regulations. Drugs, medical devices, and medical consumables used in the provision of health care in first-level health facilities must be paid for by funds obtained from the capitation of BPJS Health.

If we look at the rate of utilization of family planning services in different provinces, in 27 of the 33 provinces the utilization of private services is higher than 60%, while in 6 provinces' reliance on the government sources is still higher than 40%. Among the six provinces, the reliance of Gorontalo, South Sulawesi, and NTB Provinces is between 40.5 % - 42.4 %, while NTT, Papua and West Papua Provinces it is over 50 %. The challenge is that there should be efforts to improve the utilization of private sources of services in general, but the improvement in the government sector in some regions still needs to be realized. This is important as the basis for the planning in BPJS in the drafting of cooperative agreements with private service facilities.

At this time the government provides three types of contraceptive methods,namely condoms, IUDs and implants, free of charge in all regions in Indonesia. In seven provinces, in addition to those three types of contraception, other contraceptive methods are also provided free of charge. The seven provinces are Aceh, West Nusa Tenggara, East Nusa Tenggara, Maluku, North Maluku, Papua, and West Papua Provinces. In other provinces, in addition to condoms, IUDs and implants, other contraceptive drugs or devices are available for free only for the poor (Pre-Prosperous and Prosperous Family 1). In other words, some people have to pay for their own use of contraception. Under the National Health Insurance (JKN), contraceptive methods for the participants of JKN are provided by BKKBN in coordination with the Ministry of Health and Social Security Organizing Agency (BPJS).

3.3.2.Health Services System

Availability of resources for family planning services.

For primary healthcare facilities, the government has provided 9,510 Puskesmas, supported by 23,059 Pustu, supported by community-based health facilities namely 51,996 Poskesdes and Polindes (Pusdatin, 2012). Results of Risfaskes(Health Facilities Research) in 2011 showed that 32.6% Puskesmashave a special clinic for family planning services (ranging from the highest or 66.4% in Jakarta, 51.4% in Aceh and 45.6% in West Sumatra to the lowest 12.9 % in Southeast Sulawesi, 16.2% Gorontalo and 20.5% in Maluku). Secondary and tertiary health services facilities available include 833 Government Hospitals, 67 BUMN (State-Owned Enterprises) Hospital, 721 non-profit Private Hospitals, and 548 Private Hospitals.

The availability of health personnel as family planning service providers has improved, even though the number has not reached the desired target and it has not been evenly distributed throughout Indonesia. The desired target is the availability of 100 midwives per 100,000 people. Currently the availability is only 49.5 midwives per 100,000 people. Both Aceh and Bengkulu Provinces have the best ratio, respectively at 193.4 and 142.3 midwives per 100,000 people. The lowest ratio is found in Jakarta and West Java, respectively at 21.5 and 23.5 midwives per 100,000 people. The target of availability of general practitioners is 40 per 100,000 people. However, currently only at the national level the availability is at 13.6 general practitioners per 100,000 people. The highest ratio is found in North Sulawesi and Yogyakarta Provinces, respectively at 38.7 and 35.5 general practitioners per 100,000 people. In the meantime, the lowest ratio is found in West Java and East Java Provinces, respectively at 6.4 and 7.4 general practitioners per 100,000 people (Pusdatin, April 2013).

Since 1997 there has been a shift in the utilization of contraceptive services by family planning clients as they has increasingly preferred the private facilities rather than the government services as indicated

by the results of the IDHS in 1997, 2003 and 2007. The trend in the utilization of private facilities for contraceptive services has consistently increased from 42% to 63% and to 69%, while in the government service facilities the number decreased from 43% to 28% and to 22%. The results of RIskesdasin 2010 show that percentage of people who get family planning services from the private facility or Independently Practicing Midwives is 52.5 %, while the proportion of those receiving the services from the government care facilities such as hospitals, Puskesmas, PustuandPoskesdes or Polindes is at 23.9%.

Accessibility of Family Planning Services

Public access to basic health services increases as there is an increasing number of Puskesmas (including Pustu), the increasing presence of Poskesdes and Polindes in each village, and the provision of insurance for basic health services for the poor. Nevertheless, access to health care services is not evenly distributed yet throughout Indonesia.In the Isolated Areas, Border Areas and Islands (DTPK), the availability of health care facilities and personnel is limited. DTPK should be made a priority because of the disparities between DTPK and non DTPK. Common problems in DTPK are their geography which is hard to reach, frequently changing climate/weather, lack of basic infrastructure (access to transportation, electricity, water, communication, education, and health), the high cost of living, lack of qualified human resources, high rate of poverty, and less integration in the implementation of activities in the border regions, partial construction and limited investment. The goal of health development for 2010-2014 in DTPK is to increase the scope and equal distribution of quality health care services for the community in DTPK to a target of 101 Puskesmas in 45 districts with border regions and 50 districts of 183 underdeveloped districts.

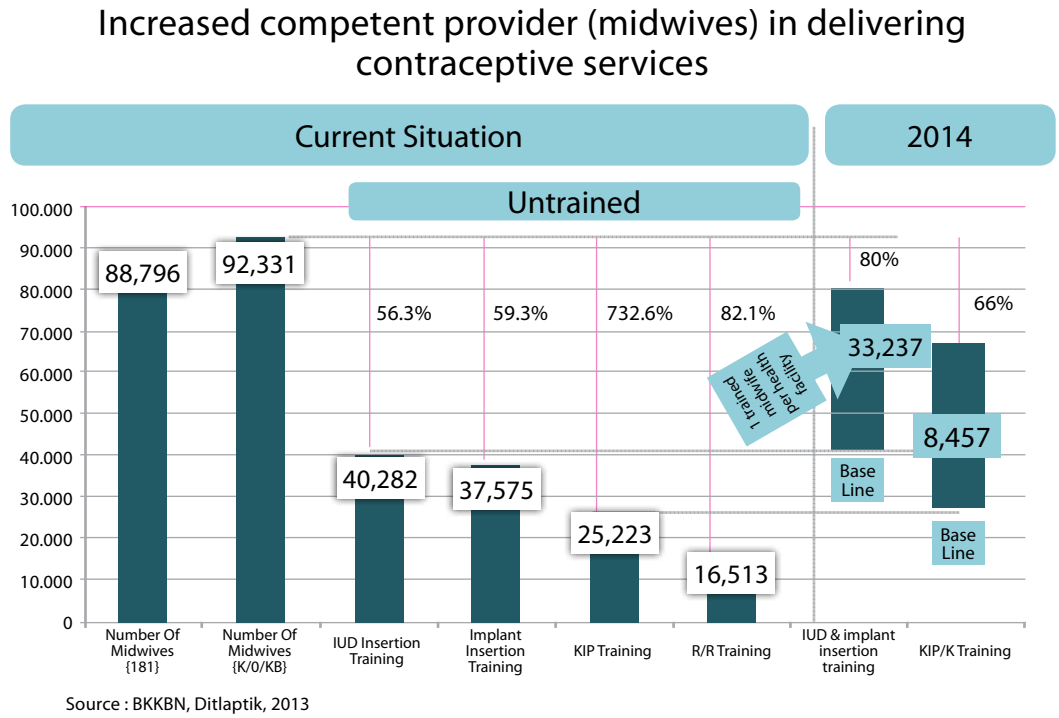
Quality of Family Planning Services

Quality family planning services will give satisfaction to the clients as well as ensuring compliance with the procedures for the implementation of family planning services in accordance with the code of conduct and service standards that have been established. From the perspective of service standards, quality family planning services are achieved when the rate of complications, dropout in contraceptive use or failure of contraceptive methodsis low or within a tolerable limit. The annual data from Maternal and Child Health Program in 2012 shows that the rates of complications, dropout or failure of contraceptive methods are low or within a tolerable limit or respectively at 2.24%, 2.61%, and 0.06%. Nevertheless, the quality of family planning services still need to be improved.

The competency of the personnel who provides family planning services is a factor that greatly affects the quality of family planning services in addition to other factors such as the support infrastructure and facilities, contraceptive methods and drugs, availability of service guidelines and efforts to maintain the quality. The two figures below present the training needs for midwives and doctors, which indirectly suggest the level of competency of health workers in providing family planning services. Recent data shows that of 92 331 registered midwives who provide family planning services, about 56.3% of them have not received any training on IUD, 59.3% have not received any training on contraceptive implant and 73.3 % have not received any training on KIP/K. In the meantime, 23,777 registered doctors who provide family planning services, about 64.5% of them have not received any training on IUD, 68% have not received any training on contraceptive implant, 87.9% have not received any training on female surgical method (tubectomy), 89.5 % have not received any training on the male surgical method (vasectomy), and 77. 9 % have not received any training on KIP/K. Therefore, it is necessary to increase the capacity of health workers in providing family planning services by giving the pre-service and in-service training.

During the period of 2012-2013, ToT on Postpartum Family Planning was implemented in 33 provinces. Furthermore, the provinces Training held on Postpartum Family Planning focusing on Postpartum IUD for health workers, both in Puskesmas or hospitals. In 2012, 675 health workers from Puskesmas or district/city hospitals

received training on Postpartum Family Planning. This means that it has reached the target of the Presidential Instruction 2A on the strategy and activities to accelerate the decline in MMR, that is to ensure the availability of 643 health workers in Puskesmas and hospitals. In the meantime in 2013, by September 2013 health workers from 397 Puskesmas and hospitals have received training, while the target is 681 Puskesmas and hospitals.



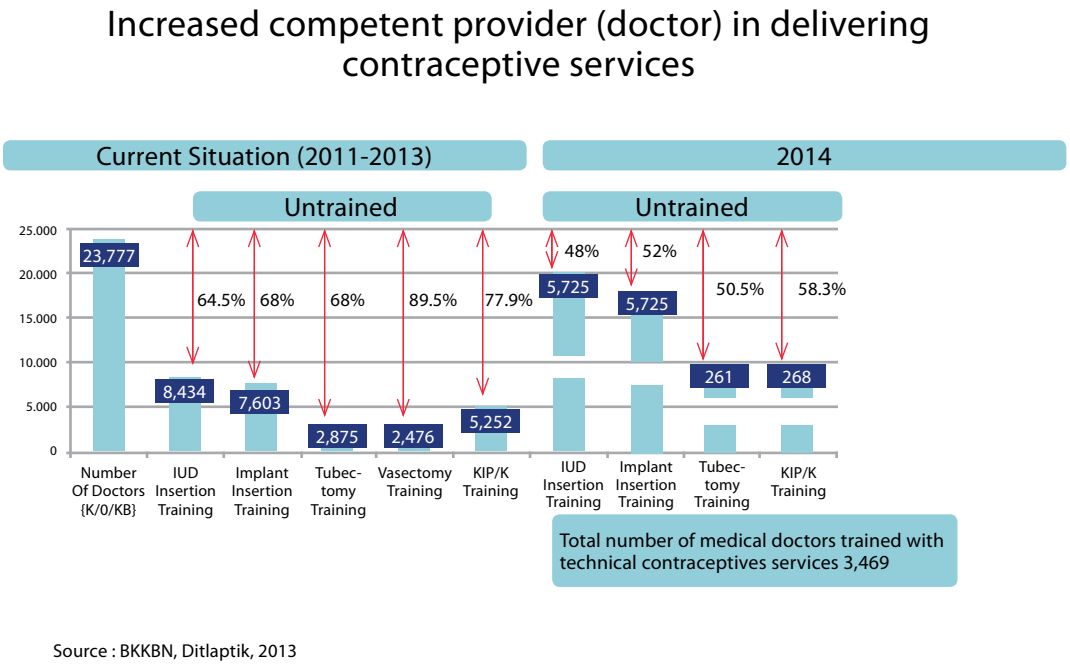


Figure 3.5.
Need for Training on Family Planning Services for Midwives and Doctors in 2013-2014

3.4. Characteristics of Population

3.4.1.Supporting Characteristics

Population Size, Growth and Composition

Law of the Republic of Indonesia Number 17 of 2007 on the National Long-Term Development Plan (RPJPN) for 2005-2025 states in its appendix that the development of human resources is aimed at improving the quality of Indonesian human resources marked, among other things, by an increase in Human Development Index (HDI) and Gender Development Index (GDI), as well as the achievement of balanced population growth marked by Net Reproductive Rate (NRR) at 1 and TFR at 2.1.

In 2000 Indonesian population reached 206.3 million with the population growth rate at 1.45 % during the period of 1990-2000. The National Development Planning Agency (Bappenas) and the Indonesian Statistics (BPS) projected the population of Indonesia to reach 234.1 million people by 2010 with the population growth rate at 1.21%. The result of the 2010 Population Census shows that the Indonesia population was 237.6 million, approximately 4 million people higher than predicted. During the period of 2000-2010 the population increased by 1.49% (BPS, 2010).

The 2000 Population Census data shows that the majority of the population was the productive age group (15-59 years old), at 65.03%. The figure is followed by the younger age group (0-14 years old), at 30.43% and the older age group (above 65 years old), at 4.54%. The condition is relatively stable, since only the proportion of younger age group experienced a slight decrease and the population of productive age group and that of older age group experienced a slight increase. The median age of the population becomes older, from 23.78 years old according to the 2000 Census to 27.2 years according to the 2010 Census. Accordingly, Indonesia population can be categorized as intermediate population, which means the transition from young population to older population.

Marriage Patterns

The results of the 2010 Population Census reveals that of the total population aged 10 years old or above who are married, approximately 2.1% of them are under the age of 19 years. Almost 37% of these people have a child and 2.5 % have more than one child. The result of National Social Economic Survey (NSES) in 2009 shows that of total population of adolescents aged 15-19 years, 3% are married (girls at 5.4% and boys %). The proportion of unmarried male adolescents was higher than that of female adolescents. The proportion of divorced and are widowed adolescents is higher among female adolescents than male ones.

Population Distribution

Population distribution in Indonesia is uneven. This uneven distribution is partly caused by high rate of urbanization. The rapid growth rate of the urban population due to urbanization causes a variety of problems, including a decline in the quality of the environment, the emergence of settlements that are less healthy, reduction of employment and other socioeconomic problems. This rapid population growth must be balanced by an increase in the fulfillment of good quality and greater amount of the people's necessities. The following figure shows that since 1930 the population has been concentrated in Java Island. In 2010 it is recorded that approximately 58 % of Indonesia's population lived in Java and Madura Islands.

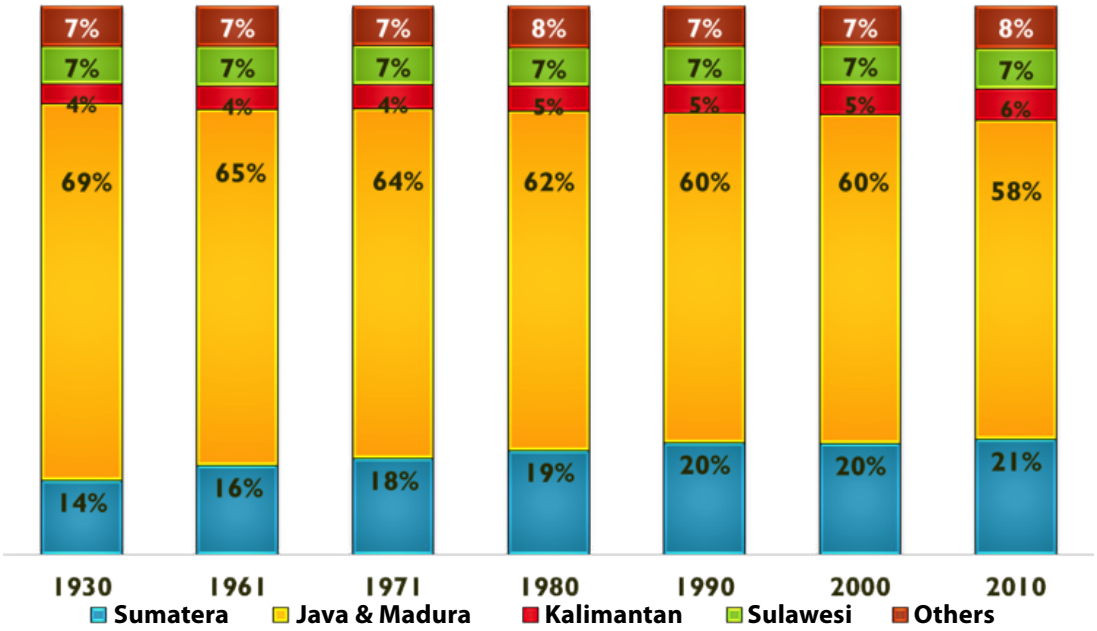


Figure3.6.
Population Distribution Pattern in Indonesia

3.4.2.Enabling factors

Level of Education

Approximately 8.4% of Indonesia's population aged 15 years and above did not /had not graduated from elementary school (SD), 25 % graduated from elementary school, 21% graduated from junior high school (SMP) and 30% graduated from high school (SMA). The relatively high proportion of the population aged 15 years and above who did not / had not completed elementary school and graduated from elementary school indicates that the quality of human resources in Indonesia is still low.

There is an inverse relationship between education of girls and women and age at which they first get pregnant. Women with lower education are likely to become pregnant at a younger age. Approximately 16% of girls who did not go to school have started to have children compared with 1% of girls who went to high school or a higher level of education. The level of education is generally positively correlated with the economic level, which is then found to be related to the age of marriage. 2012 IDHS shows that approximately 17% of female adolescents who are in the bottom quintile of the socioeconomic status have become mothers, while among adolescents who are in the top quintile of the economic status only 3 % have given birth to their children.

Knowledge and Beliefs

Knowledge is a dominant factor which shapes one's actions. One aspect of knowledge about birth control and family planning is the knowledge about various available methods/ devices of contraception. Based on 2012 IDHS it is known that 99% of married women have heard of a method / device of contraception. The most well known method of contraception is birth control pills (97%) and contraceptive injection (98%). In general, the age group of 30-34 years old who live the urban areas and have a high level of education have the largest amount of knowledge about contraceptive methods. In the meantime, married women aged 15-24 years old who live in rural areas and less educated have the lowest knowledge about contraceptive methods.

Approximately 97% of married men know about contraceptive methods. However, only about 63% know about implants and 65 % know about the intrauterine device (IUDs). This is due to the limited exposure to information about contraception and reproductive health among married men. Approximately 40 % of married men are not exposed to family planning messages through the media or through direct contact with health workers and/or family planning field workers.

3.4.3.Needs

Desire to Have Children and Ideal Number of Children.

Nearly 50% of married women stated that they do not want to have another child (including those who have undergone sterilization). This group is presumably to perform birth spacing. Approximately 15% of married women said they want to have another child immediately; 6% of them have not decided when they want to have another child; and 5 % have not decided whether they want to have another child. Most of (about 50 %) of respondents of IDHS 2012, both women and men, stated that they want to have 2 children and about 20 % of them stated that they want 3 children. Only very small percentage of the respondents stated that they want to have 5 or more children.

As expected, women and men with a lot of parity indicate a desire to have more children. Among women who are or were once married and have one child, their average ideal number of children is 2.4, whereas among women who are or were once married and have six or more children, the average ideal number of children is 4.1. Among married men, the average ideal number of children ranges from 2.5 among those who have one child to 4.7 among those who have 6 or more children.

The 2012 IDHS also finds that women and men in Indonesia have more children than what they have expected. As many as 43 % of men who have 5 or more children stated that their ideal number of children is smaller than their actual number of children. More than half of women and men who have not had any children yet stated that their ideal number of children is 2.

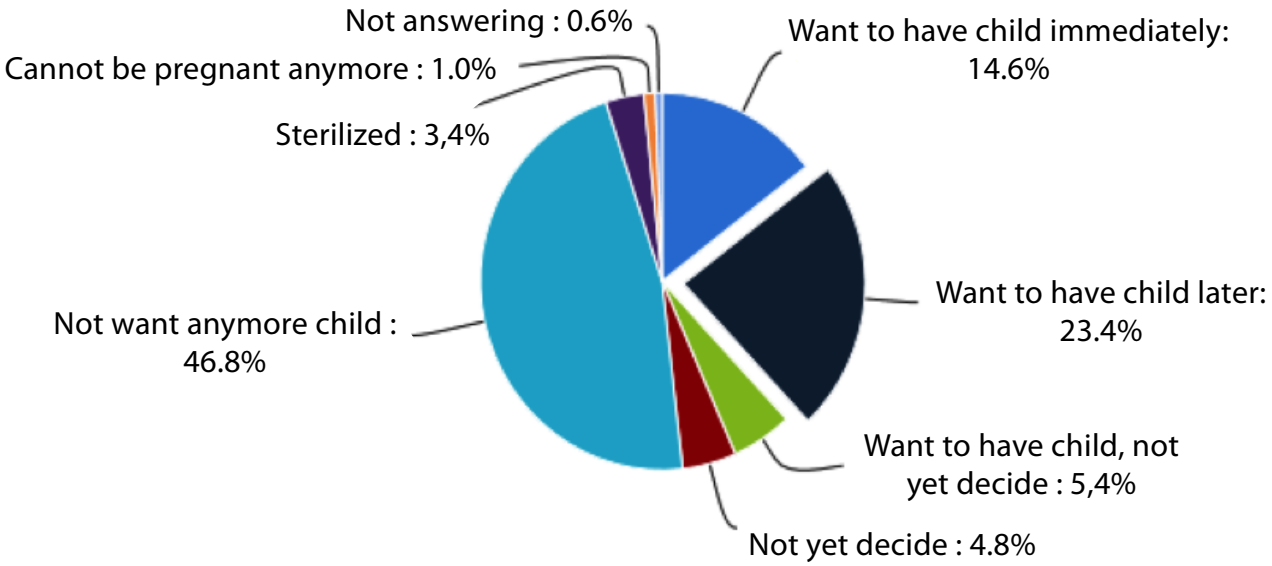


Figure 3.7.
Women's Desire to Have Another Child

3.5. Health-related Behavior

3.5.1.Individual Health Options

Early Marriage

The further analysis of the 2007 IDHS data was conducted to identify the trend in early marriage. The analysis shows that the proportion of respondents who were married for the first time at the age of under 18 years old in the group of those who got married 5-10 years ago is higher than the group of those who got married more than 15 years ago. We can see that the proportion of women who married early increased again in the last 10 years after figure experienced a gradual decline.

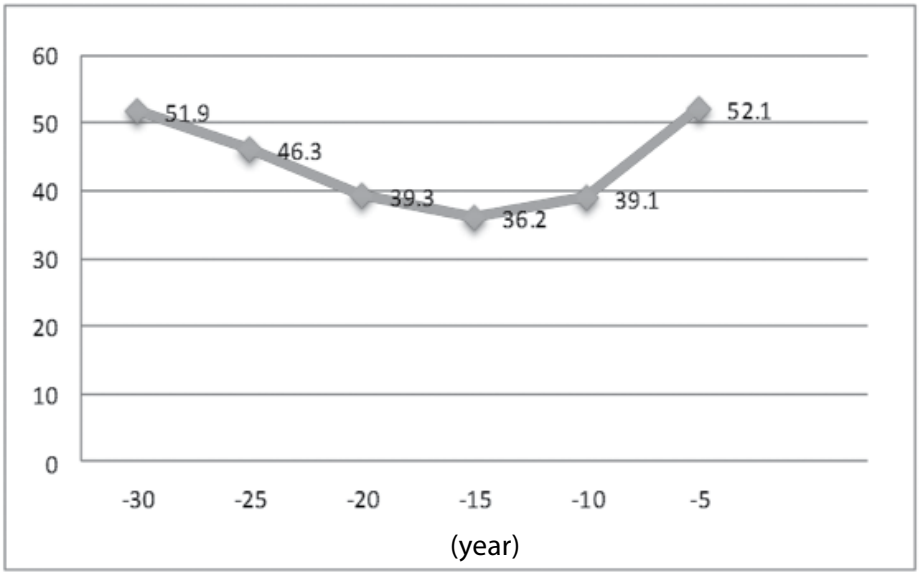


Figure 3.8.
Early Marriage of Those Under 18 Years Old

Choice of Types of Contraceptive Drugs/Devices

Most family planning participants actively use hormonal and short term contraceptive methods, with the highest proportion being found in the use of contraceptive injections. This trend has been stable since 1987. The use of contraceptive injections increased from 28% in 2002 (2002-2003 IDHS) to 31.6% in 2007 (2007 IDHS) and to 31.9% in 2012 (2012 IDHS). The use of long-term contraceptive methods such as sterilization (tubal ligation and vasectomy), IUD, and implant has shown a tendency to decrease. The use of IUD, for example, decreased from approximately 6.4% in 2002 (2002-2003 IDHS) to 4.8% in 2007 (2007 IDHS) and 3.9% in 2012 (2012 IDHS).

Male participation

The results of 2002-2003 IDHS showed that only about 1.3% of men used contraceptives; 0.9 % used condoms and 0.4% underwent male sterilization. This percentage increased slightly in 2012 to 2.7% (2012 IDHS); 0.3 % underwent male sterilization and 2.5 % used condoms. The low participation of men in contraceptive use is influenced by several factors including knowledge, attitude of men towards family planning and the socio - cultural conditions of the community. Men who do not have sufficient knowledge about family planning will not be motivated to participate in contraceptive use.

3.5.2.Utilization of Family Planning Services

Unmet Need

The result of 2012 IDHS that used a new calculation indicates that 11% of married women in Indonesia have unmet needs for family planning services. About 4% of them want to delay the next pregnancy for a period of 2 years or more and 7% actually do not want to have another child. Approximately 62% of the family planning needs which are met, 27% used contraceptive methods for spacing birth and 35 % used them to limit the number of children. The current percentage of married women who need family planning services in Indonesia is around 73 %. Approximately 85% of them have met their needs. Thus, if all of the needs for family planning are met, the contraceptive prevalence among married women in Indonesia at this time can be increased from 62% to 73%.

The need for family planning services which are unmet vary by age group. Married women aged 35-49 years old tend to have a greater need for contraceptive services than young women aged 15-34 years old do. There is no difference between urban women and rural women in terms of the fulfillment of their need for family planning services, even though the need for the services in urban areas is to limit births, while rural women need the services to space births.

The number of family planning needs which are met tends to increase as the level of education of women increases, ranging from 76 % for women who never attended school up to 87 % for women who graduated from high school. The needs which met also show a rise as there is an increasing number of children who are born alive, from 66% to 71 % among women who do not have children or higher for women who have one or more children.

If the unmet need is calculated using the old formula, it will appear that the situation described by 2012 IDHS has not much changed compared with the situation described by the 2007 IDHS. The following figure presents the unmet need as described in1991-2012 IDHS.

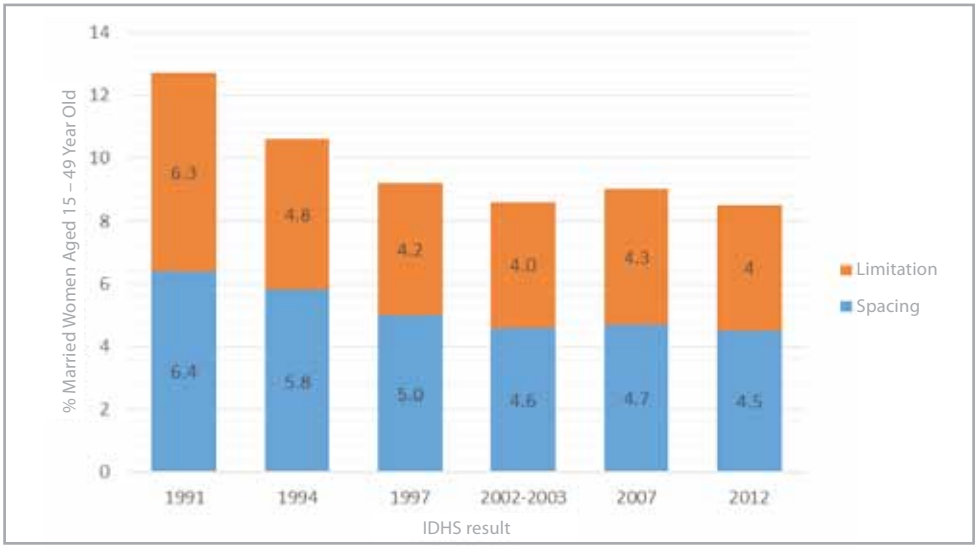


Figure 3.9.
Trend of Unmet Need between 1991-2012

Several factors which are expected to influence the occurrence of unmet need include age, education, number of living children, the husband's attitude towards family planning, prior experience in using contraceptives, economic activity andwelfare index. Unmet need is frequently found to be related to concerns about side effects of and discomfort from contraceptive use. As many as 12.3% of women aged 15-49 years did not want to use contraceptives because they feared the side effects, 10.1% did not want

to use contraceptives because of health problems, and 3.1 % of them were prohibited by their husband (the reason for unmet need can be more than one). This data suggests that reducing the unmet need requires reinforcement in the counseling service, both in terms of its scope and quality. It is also evident that the unmet need is associated with low quality of family planning services.

The unmet need and CPR will affect TFR, which in turn will affect MMR. The unmet need can lead to unwanted pregnancy, the rate of which is quite high in Indonesia. It is estimated that approximately 6% -16% of maternal deaths are caused by unsafe abortions performed to deal with an unwanted pregnancy.

Contraceptive Prevalence Rate

The results of 2007 and 2012 IDHS show no significant increase in CPR. CPR for modern methods increased from 56.7% in 2007 to 57.9% in 2012. The gap in CPR between provinces indicates uneven distribution of family planning services throughout Indonesia. The figure has appeared to be obviously stagnant during the past ten years.

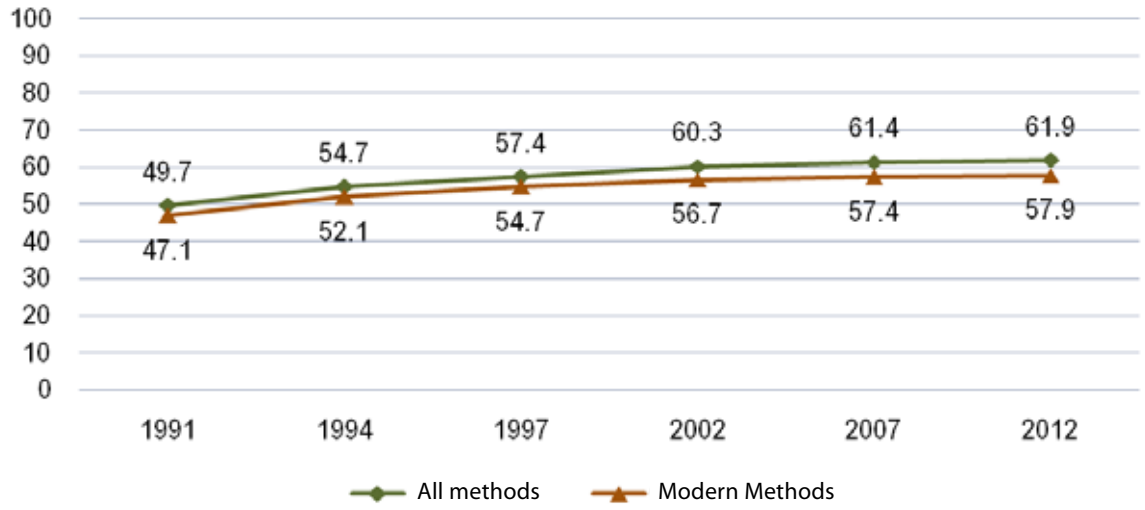


Figure 3.10.
Trend of CPR in Indonesia in the Past 20 Years
According to Results of IDHS

Interregional Disparity

The following figure illustrates the uneven CPR in various regions in Indonesia. The lowest CPR is found in New Guinea (19.1%) and the highest is found in Central Kalimantan (66.4%). CPR in the urban areas (63%) is slightly higher than that in rural areas (61%). The 2012 IDHS indicates that the use of modern methods is relatively similar in both urban and rural areas (respectively at 57% and 58%).

Injectables is one method which is widely used, at 31.1%. More people in rural areas tend to use this method of contraceptive compared to those in the urban areas. Most of family planning services are performed by independently practicing midwives (52.5%). Only 12% are obtained in Puskesmas and 4.1% in Polindes/Poskesdes. The contraceptive prevalence rate generally increases as the education level and socioeconomic level of the people increase.

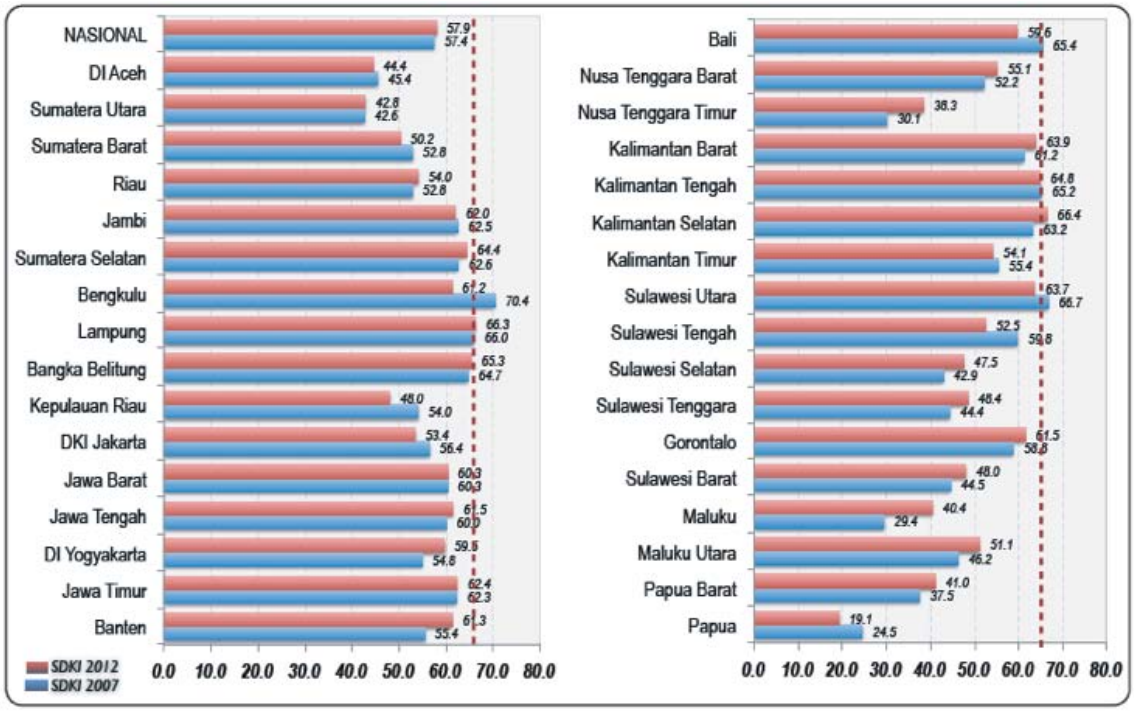


Figure 3.11.
CPR in Different Provinces in Indonesia based on 2007 IDHS and 2012 IDHS

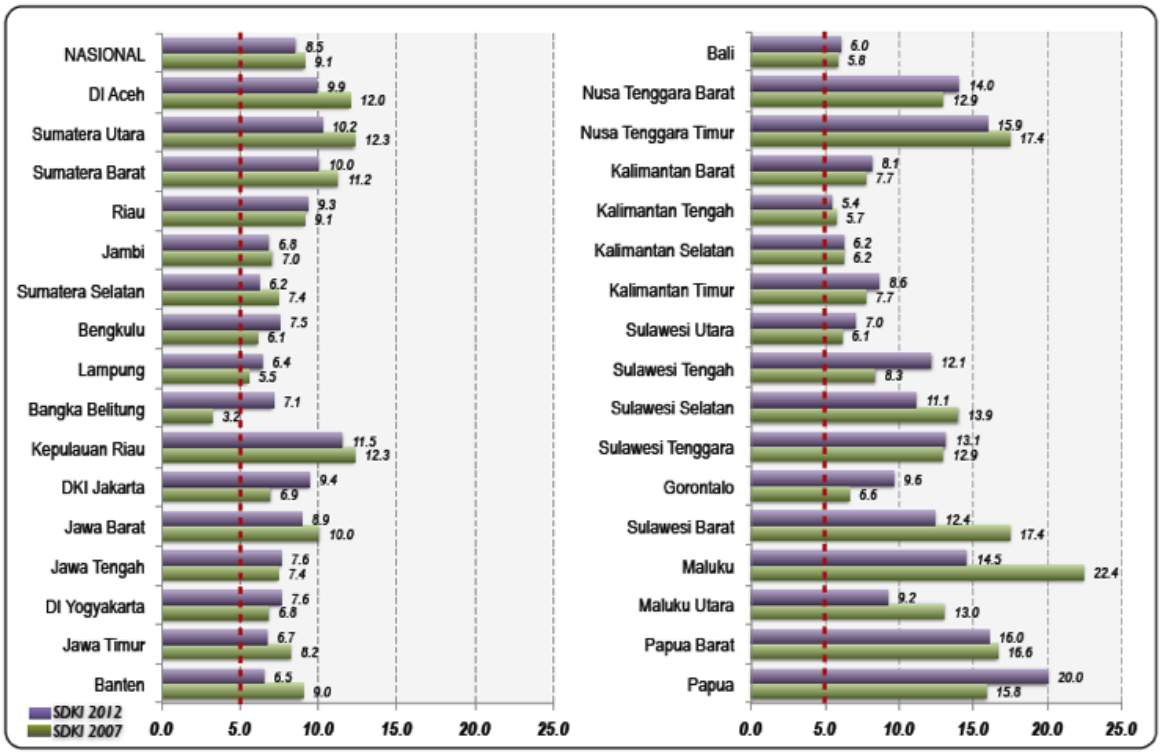


Figure 3.12.
Unmet Needin Different Provinces in Indonesia
Based on 2007 IDHS and 2012 IDHS

Unmet need also varies between different provinces, between regions and between socio-economic statuses. The result of 2012 IDHS indicates that the lowest unmet need is found in Central Kalimantan

(5.4%) and the highest is found in Papua (20%). The unmet need in rural areas (9.2%) is higher than the figure in urban areas (8.7%).

The unmet need among women with a low level of education is higher than the unmet need among those with a higher education level, i.e. 11% to 8%. The unmet need among women at the lowest quintile for the level of economic at 13% is higher than the women at the highest quintile at 8%. This indicates that the higher the level of education and social welfare of women, the increasingly higher their access to information and family planning services and reproductive health.

CHAPTER 4 : NATIONAL ACTION PLAN FOR FAMILY PLANNING SERVICES

The National Action Plan for Family Planning Services is implemented in the context of decentralization that guarantees strong integration in the planning of development in health sector as well as in the allocation of the budget with a focus on family planning services. The following figure describes strategic issues that are identified, strategies used and the key programs being developed.

Strategic Issues:

1. Lack of commitment of stakeholders, both the government and non government stakeholders, in organizing family planning services.
2. Less optimal availability, affordability, and quality of family planning services including IEC and counselingservices.
3. Low demand for family planning services due to changesin values regarding the ideal number of children in the family.
4. High rate of unwanted pregnancy due to high unmet need and low sustainability in the use of contraceptives.
5. High rate of teen pregnancy and childbirth among girls aged 15-19 years old.

Strategies:

1. To strengthen the commitment of stakeholders, both the government and non government stakeholders, in organizing family planning services.
2. To increasethe availability, affordability, and quality of family planning services including IEC and counselingservices.
3. To increase the demand for family planning services due to changesin values regarding the ideal number of children in the family
4. To reducethe unmet need by improving access, counseling, and to strengthen postpartum use of contraceptives as well as decreasing the reluctance to continually use contraceptives through increased use of MKJP and family planning coaching
5 To lowerthe rate of pregnancy among teens aged 15-19 years old by encouraging them to get married at older age and improving their knowledge of adolescent reproductive health

Key Programs :

1. to ensure the existence of effective policy and regulatory support in organizing family planning services
2. to improve the managerial capacity of the organizers of KKB programs and family planning services
3. to strengthen the coordination between various work units relevant in the organizers of family planning services
4. to conduct advocacy efforts in a systematic and effective manner to obtain the support and participation of various ministries and government agencies, non-governmental organizations, as well as civil society organizations.
5. to ensure the availability of a wide range of resources in terms of the types, quantity and quality to provide quality family planning services
6. to ensure that the whole population can afford and obtain family planning services, to provide quality IEC and counseling services in a systematic and effective manner and to instill the values of "two children is enough" and 4 "too's" prevention and to encourage acceptance of the use of contraceptives.
7. to involve community, traditional and religious leaders in instilling the values of "two children is enough" and 4 "too's" prevention and in encouraging acceptance of the use of contraceptives
8. toincrease the participation of men in family planning.
9. to prevent the occurrence of unmet need and increase the use of MKJP through improved knowledge about rational selection of contraceptive methods
10. tolower the incidence of side effects through the provision of quality family planning services and to ensure side effects are dealt with promptly and appropriately.
11. to ensure compliance of users with standard use of contraceptives through quality counseling services
12. to increase the range and quality of IEC and counseling services for adolescents to improve their knowledge, attitude and behavior related to reproductive health and family planning

Figure 4.1.
Framework of National Action Plan for Family Planning Services for 2014-2015

4.1. Strategic Issues

The results of the situation analysis show that there are some strategic issues in the implementation of family planning services as follows:

1. Lack of commitment of stakeholders, both the government and non government stakeholders, in organizing family planning services.
2. Low demand for family planning services due to changes in values regarding the ideal number of children in the family.
3. Less optimal availability, affordability, and quality of family planning services including IEC and counseling services.
4. High rate of unwanted pregnancy due to high unmet need and low sustainability in the use of contraceptives.
5. High rate of adolescents pregnancy and childbirth among girls aged 15-19 years old.

4.2. Goals and Strategies

The following table summarizes the strategies prepared to address the issues that have been identified based on the strategic goals to be achieved with regard to each strategic issue.

Table 4.1.
Strategic Issues, Goals and Strategies

Strategic Issue	Goal	Strategy
1. Lack of commitment of stakeholders, both the government and non government stakeholders, in organizing family planning services	1.1. The existence of more powerful and effective policies and regulations in organizing family planning services 1.2. The existence of more powerful and effective support and participation in organizing family planning services from non-government (private, organizations and community) 1.3. Increased managerial capacity in organizing family planning services	Strategy 1 To strengthen the commitment of stakeholders, both the government and non government stakeholders, in organizing family planning services
2. Less optimal availability, affordability, and quality of family planning services including IEC and counseling services	2.1. Guaranteed availability of resources (personnel, service facilities, equipment, contraceptive methods) for the provision of family planning services, including IEC and counseling services 2.2. Guaranteed availability of services, including IEC and counseling services 2.3. Guaranteed affordability of family planning services by the entire society, including IEC and counseling services 2.4. Guaranteed quality of family planning services, including IEC and counseling services	Strategy2 To increase the availability, affordability, and quality of family planning services including IEC and counseling services

3. Low demand for family planning services due to changes in values regarding the ideal number of children in the family	3.1. A change in the value of the people about the ideal number of children in the family to "two children is enough" 3.2. Improved public understanding of the importance of "4 too's" prevention. 3.3. Improved public understanding of contraceptive methods 3.4. Increased support of religious / customary / other community leaders to the value of "two children is enough", the importance of "4 too's" prevention, and the acceptance of contraception. 3.5. Increased participation of men in family planning	Strategy 3 To increase the demand for family planning services due to changes in values regarding the ideal number of children in the family
4. High rate of unwanted pregnancy due to high unmet need and low sustainability in the use of contraceptives	4.1. Increased use of long-term contraceptive methods 4.2. Decreased incidence of unmet need 4.3. Decreased dropout of contraceptive use 4.4. Decreased incidence of contraceptive failure 4.5. Decreased incidence of contraceptive complications	Strategy 4 To reduce the unmet need by improving access, counseling, and to strengthen postpartum use of contraceptives as well as decreasing the reluctance to continually use contraceptives through increased use of MKJP and family planning coaching
5. High rate of adolescents pregnancy and childbirth among girls aged 15-19 years old	5.1. Increased adolescents' access to reproductive health services 5.2. Improved knowledge, attitude and behavior of adolescentsagers with regard to reproductive health 5.3. Increased average age of first marriage	Strategy 5 To lower the rate of pregnancy among adolescents aged 15-19 years old by encouraging them to get married at older age and improving their knowledge of adolescent reproductive health

4.3. Strategies and Programs

4.3.1.Paying Attention to the Primary Buffer Regions

In order to achieve the targets of MDGs by 2015 some special efforts need to be focused on those regions that will provide big leverage for the achievement of the targets. This is a region that has the largest population and a region which has the highest level of unmet need. Considering both of those criteria, the development and improvement of participation in family planning through intensification in the development of family planning in 9 focused provinces is a good decision. The ten provinces are North Sumatra, South Sumatra, Lampung, West Java, Banten, DKI Jakarta, Central Java, East Java, and South Sulawesi. More specific attention should be directed to the provinces in Java Island, since approximately 60% of the population of Indonesia is on this island.

4.3.2.Strategies, Key Programsand Sub-Programs

The following table presents various programs for each strategy along with their sub-programs.

Table 4.2.
Strategies, Key Programs dan Sub-Programs

Strategy	Key Program	Sub-Program
Strategy 1 : **To strengthen the commitment of stakeholders, both the government and non government stakeholders, in organizing family planning services**	1.1. To ensure the existence of effective policy and regulatory support in organizing family planning services	1.1.1. To develop effective regulations to support the implementation of family planning services by strengthening the institutional structures and capacities of KKB Program
		1.1.2. To disseminate Minimum Service Standards of family planning – prosperous family
		1.1.3. To conduct monitoring and evaluation of compliance with Service Standards of family planning – prosperous family
		1.1.4. To review laws and regulations related to the medical practice and family planning services (midwife, CTU, and other topics)
		1.1.5. Family planning services at health facilities
	1.2. To improve the managerial capacity of the organizers of KKB programs and family planning service at different administrative levels	1.2.1. To hold KKB management training program for organizers of KKB Program at different administrative levels.
		1.2.2. To hold family planning service management training program for organizers of family planning services at different administrative levels

Strategy	Key Program	Sub-Program
	1.3. To strengthen the coordination between various relevant work units in the organizers of family planning servicesat different administrative levels	1.3.1. To issue a ministerial decree (SK) related to cross-sectoral cooperation in family planning services and cooperation between various administrative levels.
		1.3.2. To conduct supervision and facilitation in the region
		1.3.3. To improve coordination of family planning services
	1.4. To conduct advocacy efforts in a systematic and effective manner to obtain the support and participation of various ministries and government agencies, non-governmental organizations, as well as civil society organizations, and donor agencies with regard to the organizing of KKB Program dan family planning program at different administrative levels	1.4.1. To develop an effective advocacy strategy to gain the support and participation of various ministries and government agencies, non-governmental organizations, as well as civil society organizations, and donor agencies with regard to the organizing of KKB Program dan family planning program at different administrative levels.
		1.4.2. To prepare effective advocacy materials to gain obtain the support and participation of various ministries and government agencies, non-governmental organizations, as well as civil society organizations, and donor agencies with regard to the organizing of KKB Program dan family planning program at different administrative level.
		1.4.3. To conduct effective advocacy to gain the support and participation of various ministries and government agencies, non-governmental organizations, as well as civil society organizations, and donor agencies with regard to the organizing of KKB Program dan family planning program at different administrative levels.

Strategy	Key Program	Sub-Program
Strategy 2 : **To increase the availability, affordability, and quality of family planning services including IEC and counseling services**	2.1. To ensure the availability of a wide range of resources in terms of the types, quantity and quality to provide quality family planning services, including IEC and counseling services	2.1.1. To plan, procure, and assign adequate qualified personnel to provide family planning services, including IEC and counseling services.
		2.1.2. To plan and hold training for personnel of family planning services, including IEC services, to ensure the competencies required are mastered
		2.1.3. To plan and organize health care facilities which provide quality family planning services, including IEC and counseling services.
		2.1.4. To plan, procure and distribute different kinds of quality materials and aid to provide universal IEC and Counseling services.
		2.1.5. To plan, procure and distribute different kinds of quality materials and aid to provide universal IEC and Counseling services.
		2.1.6. To plan, procure and distribute contraceptives methods which are sufficient in terms of their type, quantity and quality provide to family planning services
		2.1.7. To plan and implement measures to control the quality of family planning services at various administrative levels.
	2.2. to ensure that the whole population can afford and obtain family planning services, IEC and counseling services needed.	2.2.1. To organize family planning services, including IEC and counseling services, at health care facilities, easily accessible by the public.
		2.2.2. To conduct outreach services to reach people who do not have access to health care facilities which provide family planning services, including IEC and counseling services.
		2.2.3. To provide family planning services, including IEC and counseling services, at an affordable price.
		2.2.4. To provide financing for the poor to obtain family planning services, including IEC and counseling services.

Strategy	Key Program	Sub-Program
Strategy 3 : **To increase the demand for family planning services due to changes in values regarding the ideal number of children in the family**	3.1. To provide quality IEC and counseling services in a systematic and effective manner and to instill the values of "two children is enough" and 4 "too's" prevention and to encourage acceptance of the use of contraceptives.	3.1.1. To develop and disseminate strategies and methods in the provision of IEC services in a systematic and effective manner for instilling the value of "two children is enough", to improve understanding of the importance of 4 "too's" prevention and to encourage acceptance of the use of contraceptives.
		3.1.2. To develop, procure and distribute materials for effective IEC services to instil the value of "two children is enough", to improve understanding of the importance of 4 "too's" prevention and to encourage acceptance of the use of contraceptives.
		3.1.1. To develop understanding of pregnancy, childbirth, postpartum health, family planning and pregnancy complications and their prevention by empowering midwives, cadres and the public.
	3.2. To involve community, traditional and religious leaders in instilling the values of "two children is enough", to improve understanding of the importance of 4 "too's" prevention andacceptance of the use of contraceptives.	3.2.1. To carry out IEC activities to relevant stakeholders and community leaders in a systematic and effective manner to instill the value of "two children is enough", to improve understanding of the importance of 4 "too's" prevention and to encourage acceptance of the use of contraceptives.
		3.2.2. Together with the relevant stakeholders and community leaders to provide IEC services systematically and effectively to instill the value of "two children is enough", to improve understanding of the importance of 4 "too's" prevention and to encourage acceptance of the use of contraceptives.
		3.2.3. To conduct field preparation for mobilization of potential acceptors and active participants
		3.2.4. To provide coaching for new participants and active participants
		3.2.5. To conduct monitoring and reporting
	3.3. To increase the participation of men in family planning program.	3.3.1. To develop effective methods of IEC services for men to increase men's participation in the family planning program.

Strategy	Key Program	Sub-Program
		3.3.2. To develop, procure and distribute materials for effective IEC services for men to increase men's participation in the family planning program.
		3.3.3. Together with the relevant stakeholders and community leaders to provideeffective IEC services for men to increase men's participation in the family planning program.
Strategy 4 **To reduce the unmet need by improving access, counseling, and to strengthen postpartum use of contraceptives as well as decreasing the reluctance to continually use contraceptives through increased use of MKJP and family planning coaching**	4.1. To prevent the occurrence of unmet need and increase the use of MKJP through improved knowledge about rational selection of contraceptive methods	4.1.1. To develop methods of counseling services to increase the knowledge of potential acceptors / active acceptors on the rational selection of contraceptive methods.
		4.1.2. To develop, procure and distribute materials for effective counseling services to increase the knowledge of potential acceptors / active acceptors on the rational selection of contraceptive methods.
		4.1.3. To reorient the importance of MKJPand contraceptives after child birth.
		4.1.4. To improve the ability to provide counseling on the benefits of contraceptive methods in particular IUDs and implants.
		4.1.5. To carry out counseling in order to improve the knowledge of potential acceptors / active acceptors on rational selection of contraceptive methods.
	4.2. To lower the incidence of side effects through the provision of quality family planning services and to ensure side effects are dealt with promptly and appropriately.	4.2.1. To improve the skills of health workers in providing family planning services
		4.2.2. To improve the skills of trainers in delivering training on family planning services

Strategy	Key Program	Sub-Program
		4.2.3. To increase the capacity of educators in providing education on family planning services
		4.2.4. To guarantee the quality of family planning services by conducting facilitative supervision.
		4.2.5. To strengthen midwifery care of MKJP (IUD and implant) in hospitals and Puskesmas
	4.3. To ensure compliance of users with standard use of contraceptives through quality counseling services	4.3.1. To develop methods of counseling services to increase compliance of potential acceptors / active acceptors with standard use of contraceptives.
		4.3.2. To develop, procure and distribute materials for effective counseling services to increase compliance of potential acceptors / active acceptors with standard use of contraceptives.
		4.3.3. To conduct counseling services to increase compliance of potential acceptors / active acceptors with standard use of contraceptives.
Strategy 5 : **To lower the rate of pregnancy among adolescentss aged 15-19 years old by encouraging them to get married at older age and improving their knowledge of adolescent reproductive health**	5.1. To increase the range and quality of IEC and counseling service for adolescents to improve their knowledge, attitude and behavior related to reproductive health and family planning.	5.1.1. To develop strategies and methods in the provision of IEC and counseling services in a systematic and effective manner to improve the adolescentsagers' knowledge, attitude and behavior related to reproductive health and family planning.
		5.1.2. To develop, procure and distribute materials for effective IEC and counseling services to improve the adolescentsagers' knowledge, attitude and behavior related to reproductive health and family planning.
		5.1.3. Together with the relevant stakeholders and community leaders to provideeffective IEC and counseling services to improve the adolescentsagers' knowledge, attitude and behavior related to reproductive health and family planning.
		5.1.4. To improve the role of youth in improving their knowledge, attitude and behavior related to reproductive health and family planning.

4.4. Activities, Indicators, Targets, Methods of Verification, Units in Charge and Implementers

The National Action Plan for Family Planning Services which is presented in Appendix - 1 includes information about:

1. Strategies
2. Key Programs
3. Sub-Programs
4. Activities
5. Indicators
6. Targets
7. Methods of Verification
8. Units in Charge
9. Implementers

CHAPTER 5 : MONITORING AND EVALUATION

5.1. Indicators of the Success of Family Planning Services

The success of the Acceleration of Achievement of Targets of Family Planning Services is measured by six indicators, consisting of three output indicators and three quality indicators in family planning services. The output indicators of family planning services are CPR of modern contraceptive methods, the level of unmet need and ASFR for age group of 15-19 years old. The quality indicators are the rate of complications in contraceptive use, the rate of unsustainable use of contraception and the rate of contraceptive failure.

1. Coverage of Family Planning Active Participants or Contraceptive Prevalence Rate (CPR)

CPR is a figure which indicates the rate of couples of reproductive age who are using contraception at the time of the census is conducted against the total number of couples of reproductive age. Information about the CPR is very beneficial to be considered when establishing policies on population control and the provision of family planning services in the form of provision of contraceptive methods such as sterilization, insertion of IUD, the preparation of contraceptive methods, and counseling services to accommodate the needs and respond to the complaints of the users of contraception. The percentage of couples of reproductive who use a certain contraceptive method is calculated by dividing it by all couples of reproductive age and then multiplying the result by 100%. The CPR of modern methods is the number of couples of reproductive age that at that time use modern methods divided by the number of number of couples of reproductive age and later multiplied by 100%.

2. Unmet Need

Unmet need or the need to participate in family planning which is not met is the percentage of women of reproductive age who do not want to have any more children or want to postpone the next birth, but do not use any contraceptive methods.

3. The number of districts/cities that have at least 4 Puskesmas capable of functioning as Adolescent Friendly Health Services (PKPR)

The target is calculated using the percentage of the districts/cities which at least 4 Puskesmas which can provide PKPR of all the total number of districts/cities. Puskesmas capable of providing PKPR is Puskesmas which provides counseling to adolescents who require a contact with health workers for counseling, assists at least 1 school (public school, religious-based school) and train Cadres of Health Adolescents/Peer Counselors as much as 10% of the total number of the students in that school.

4. Percentage of Complications

A complication is an incident when a new or active user of contraceptives suffers health problems which lead to a pathological condition as a result of the process of the administration/using/insertion of contraceptive devices and drugs such as bleeding, infection/abscess, pathological fluor albus, perforation, translocation, hematoma, increase in blood pressure, change in level of hemoglobin, and device expulsion. A complication which occurs within a period of one calendar year is counted as one time, calculated by method of IUD, contraceptive implant, contraceptive injection, pill, tubectomy and vasectomy. The percentage of complications (for each contraceptive method) is the number of active participants who experience complications divided by the total number of active participants and multiplied by 100%.

5. Percentage of Dropout

Dropout is when active family planning participants discontinue their use of contraception. The percentage of dropout is the number of participants who do not continue to use of contraception divided by the number of active participants and multiplied by 100%.

6. Percentage of Contraceptive Failure

Contraceptive failure is when pregnancy occurs to an active family planning acceptor while using a method of contraception. The percentage of contraceptive failure is the number of participants who experience failure divided by the number of active participants and multiplied by 100%.

5.2. Planning and Implementation of Family Planning Services

Family planning services are managed by following the principles of program management which includes planning, implementation, monitoring and evaluation.

5.2.1.Planning of Family Planning Services

The first step in the planning of family planning services is to determine the number of targets of family planning services and calculate the needs for contraceptive methods. The planning is carried out during mini workshops and integrated with other maternal and child health services. The targets of family planning services are determined based on data collected.

5.2.2.Implementation of Family Planning Services

Family planning services are implemented by observing the following aspects:

1. Preparation

The provision of family planning services is usually preceded by counseling. Counseling can be performed on various occasions when there is a contact between potential acceptors and health workers, for example, during the antenatal examination, at the time of the making of pledge campaign (Kartu Amanat Persalinan) (integrated in P4K), antenatal classes and classes of mothers of children under five, when potential acceptors visit health workers to seek for information about family planning and/or to obtain family planning services. The main purpose of counseling is to increase the ability of potential acceptors to make the right decision with regard to the planning of their pregnancy, including the decision to

use which type of contraceptive method. The preparation phase concludes when an informed consent is filled out. Information about family planning can also be given in antenatal classes and classes of mothers of children under five.

2. Implementation

A family planning services facility one point in the chain of family planning services facilities integrated with general health in health care facilities organized by professionals i.e. specialists, general practitioners and midwives. These facilities are classified into:

a. Simple Family Planning Services Facility

A simple family planning services facility is a facility which can and has the authority provide simple contraceptive methods (condoms, vaginal spermicide), pills, contraceptive injection, IUDs and implants (if there is a trained midwife), to deal with side effects and mild complications, and to make referrals. This facility is part of Polindes (Village Birth Facility), Poskesdes (Village Health Facility) Pustu (Auxiliary Community Health Center), private clinics, private BKIA (Maternal and Child Health Facility), TNI/Polri health facilities, (public or private) family planning facilities, as well as private practice doctors and midwives.

b. Complete Family Planning Services Facility

A complete family planning services facility is a facility which can and has the authority provide simple contraceptive methods (condoms, vaginal spermicide), pills, contraceptive injection, IUDs, insertion and removal of implants and tubectomy for those who meet the requirements. This facility is part of Puskesmas, private clinics, private BKIA, TNI/Polri polyclinics, and maternity hospitals.

c. Perfect Family Planning Services Facility

A perfect family planning services facility is a facility which can and has the authority provide simple contraceptive methods (condoms, vaginal spermicide), pills, contraceptive injection, IUDs, insertion and removal of implants as well as vasectomy and tubectomy for those who meet the requirements. This facility is part of the Class C General Hospital, private General Hospital which is equivalent to the government hospital, TNI/Polri General Hospital which has obstetricians and gynecologists, surgeons, trained general practitioners, and maternity hospitals.

d. Full Family Planning Services Facility

A full family planning services facility is a facility which can and has the authority all simple contraceptive methods and recanalization services and the countermeasures of infertility. This facility is part of Class A General Hospital, TNI/Polri Class I General Hospital, private General Hospital which is equivalent to the government hospital, and Class B General Hospital which has been designated to provide recanalization services.

5.2.3.Recording and Reporting

The results of family planning services are the results of activities implemented by family planning services facilities, both in the government health facilities (Pustu, Puskesmas, government hospitals, health units of TNI/Polri), private health facilities (private practice midwives, private practice doctors, clinics where some doctors practice together, private hospitals, maternity houses, maternity hospitals), as well as by Posyandu, Polindes, and Poskesdes. Records of all activities of family planning services must be maintained using the existing family planning record-keeping formats (Family Planning Cohort, Postpartum Cohort, Family Planning/K4 Participant Status Card, and Family Planning F2) and then reported to the District/City Health Office and Local SKPD in charge of family planning.

1. Recording

Each family planning service facility maintains records of all results of family planning services in the registers of Family Planning Cohort, Postpartum Cohort, Family Planning/K4 Participant Status Card, and Family Planning F2.

2. Reporting

Each family planning service facility reports the results of services performed each month to the local Puskesmas. Each month Puskesmas receives data from all family planning service facilities in its working territory to be reported to the District/City Health Office and Local SKPD in charge of family planning. The District/City Health Office then reports the data to the Provincial Health Office which further reports it to the central level.

5.3. Monitoring and Evaluation

Monitoring of progress of the Acceleration in the Achievement of the Targets of Family Planning Services is conducted by collecting and reviewing monthly activity reports on KKB Program and family planning services. The following are some of the activities that need to be done as part of the monitoring and evaluation of the success of the Acceleration in the Achievement of the Targets of Family Planning Services.

1. Developing an integrated record keeping and reporting system which is a shared consensus among various stakeholders about the data that should be recorded and reported on a regular and tiered basis. A simple yet informative format of record-keeping and reporting as well as a simple and effective reporting flow should be developed.

2. Conducting an analysis of regular reports from the Provincial Health Office on the indicators of success of family planning services, i.e., TFR, CPR of modern contraceptive methods, ASFR of adolescents aged 15-19 years, Unwanted Pregnancy, and Unmet Need.

3. Performing periodic dissemination of information about the success rate of the family planning services to various relevant stakeholders.

4. Conducting hierarchical supervision to the provinces and districts/cities to directly observe the various problems encountered in the effort to accelerate the achievement of targets of family planning services.

5. Holding meetings of Monitoring and Evaluation Team for the success of family planning services involving all relevant family planning stakeholders, including, Ministry of Health, BKKBN, Ministry of Home Affairs, Ministry of National Development Planning, State Ministry of Women Empowerment and Child Protection, TP PKK, professional organizations (IBI, IDI, POGI, IAKMI), non-governmental organizations, and civil society organizations.

6. Carrying out annual planning which is based on data and integrated with all sources of funds that can be used to support the achievement of the targets of family planning services. In addition to the regular data, data from a variety of national surveys such as IDHS, Susenas, Riskesdas and Risfaskes can also be used in the planning process.

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NATIONAL ACTION PLAN OF FAMILY PLANNING SERVICES FOR 2014-2015

Key Programs	Sub-Programs	Activities	Indicators	Target		Verification Models	Responsible Units	Implementing Units [The Central, Province, District/Municipality]
				2014	2015			
Strategy 1: Strengthening the commitment of the stakeholders, both the government and the non-government parties, in implementing the Family Planning Service								
1.1 to ensure the existence of effective policy and regulatory support in organizing family planning services	1.1.1Developing effective regulations to support the implementation of the Family Planning service by strengthening the institutional structure and capacity of the Population and Family Planning (KKB) Program	1.1.1.1Introducing the Law No.52 of the Year 2009 to the regency/ municipality level: DPRD (Regional House of Representatives), Sekda (Regional Secretariat), Bappeda (Regional Development Planning Board)	Having Districts/Cities which own the Regional Family Planning Coordinating Board(BKKBD)	5 BKKBDs in everyprovince		The BKKBD establishment report (Regent's Decision Letter)	National Population and Family Planning Board(BKKBN) Ministry of Internal Affairs	
		1.1.1.2 Drawing up Government Regulations on the KKB Program andthe Family Information System (SIK)	Passing the Government Regulations on KKB and SIK	1 Government Regulation		The report on the drawing up of the Government regulation (State Gazette)	BKKBN Ministry of Internal Affairs	
	1.1.2 Introduction of the Minimal Service Standard of Family Planning – Prosperous Family (KB – KS)	1.1.2.1Conducting meetings together with Bappeda, DPRD, and relevant stakeholders	The Minimal Service Standard of Family Planning – Prosperous Family (KB – KS) introduced at the level of the regency/ municipality Regional Apparatus Work Unit – Family Planning (SKPD – KB) in all provinces with the priority of the year 2014 in the 10 provinces as the main pillars.	•The materials for the introduction available •Material dissemination for the Regional Government, SKPD, providers, IBI (Indonesian Midwife Association), IDI (Indonesian Doctor Association), work partners, candidates and the candidate Supervisors in the field of KB/KS (Family Planning/ Prosperous Family) (100% in the provinces of the main pillar regions)	•The materials for the introduction available •Material dissemination for the Regional Government, SKPD, providers, IBI (Indonesian Midwife Association), IDI (Indonesian Doctor Association), work partners, candidates and the candidate Supervisors in the field of KB/KS (Family Planning/Prosperous Family) (100% in all provinces	The introduction activity report	BKKBN	Central Provinces
	1.1.3Observation and evaluation to meet the Service Standard of KB-KS	1.1.3.1 Observing the indicator accomplishment of the Minimal Service Standard of KB-KS in Districts/Cities	There is a mapping for implementing the Minimal Service Standard of KB-KS in the regency/municipality level.	Counselling and Supervision in all of the program areas	Counselling and Supervisionng as well as reviewing the implementation of theactivity	The report of the mapping results and counselling &supervision		Components of the Central BKKBN Ministry of Health
	1.1.4 Reviewing the laws and regulations relevant to the doctor practice and Family Planning service (midwives, CTU [Contraception Technology Update], and other topics)	1.1.4.1 Conductingdesk review, in depth interview,and Focus Group Discussion	There is adocument of the study results.	1 document (policy brief)	1 document (policy brief)	The report of the study results	The Ministry of Health, BKKBN	
	1.1.5 Implementing the Family Planning service in a health facility	1.1.5.1 Hospitals conducting the Perfect Family Planning service	The number of hospitals which provide the Perfect Family Planning service					
		1.1.5.2 Hospitals doing the registration of the Government Health Facilities	The number of hospitals which do the registration of the Government Health Facilities (60,077 consisting of 766 hospitals, 9321 Community Health Centers[Puskesmas], 53,152 Village Health Posts [Poskesdes]/Village Maternity Houses [Polindes])	95% of the Government Health Facilities doing registration			Ministry of Health Province	BKKBN Provincial Health Office District/MunicipalHealth Office

Key Programs	Sub-Programs	Activities	Indicators	Target		Verification Models	Responsible Units	Implementing Units [The Central, Province, District/Municipality]
				2014	2015			
1.2 to improve the managerial capacity of the organizers of KKB programs and family planning services at different administrative levels	1.2.1 Conducting the KKB Program management trainings for the implementors of the KKB Program at various administrative levels	1.2.1.1 Conducting the KKB Program management trainings for the implementors of the KKB Program at the provincial and regency/municipality levels	The program implementors trained in the field for commodity management, the contraception tool and drug distribution system, and the program facility	Implemented in 10 provinces as the main pillar areas	Implemented in all areas of the provinces which have not been covered in 2014	The counselling and supervision report	Supervision Department of BKKBN	Central Provinces
	1.2.2 Giving management trainings of the Family Training Service for the Family Training Service implementors at various administrative levels	1.2.2.1 The strengthening of the Long-Term Contraception Method(MKJP)for provinces	Provincial CPR increasing	60.1% (2030 Hospitals, 6871 Maternity Clinics, dan 8674 Community Health Centers)	60.1%	The Report of RPJMN (the National Medium-Term Development Plan) Minisurvey and Survey (BKKBN)	Directorate of Maternal Health Training and Development Department of BKKBN	BKKBN Provincial Health Office District/MunicipalHealth Office
		1.2.2.2.The MKJP activation	The number of Human Resources in implementing the MKJP activation in provinces and Districts/Cities	7,871,980 MKJP acceptors				
		1.2.2.3. Counselling on the participation of KB MKJP for providers	The number of providers in Family Planning Clinics per village	1 Family Planning Clinic per village		The counselling and supervision report	BKKBN	BKKBN
1.3 to strengthen the coordination between various work units relevant in the organizers of family planning services at different administrative level	1.3.1 Issuing the Letter of Decision of the relevant Minister in the cross sector Family Planning service cooperation and among various administrative levels	1.3.1.1Compiling the materials	1 law and regulation product (the Letter of Decision)	100%		The Issue of the Letter of Decision	Central BIHOM (Law Bureau, Organizations, and Society Relations) of BKKBN	BKKBN Ministry of Health
	1.3.2 Supervision and facilitation to regions	1.3.2.1Supervision and facilitation to regionsin the Increase of the Coverage and Quality of Family Planning Service	The provincesfocusing on obtaining supervision and facilitation	twice a yearin all the main pillar province areas	twice a yearin all the main pillar province areas		Directorate of Maternal Health Central/ Provincial Supervision Department of BKKBN	Directorate of Maternal Health Central Provincial Auditors
	1.3.3 Increase of Family Planning Service coordination	1.3.3.1The Government and Private Institution Coordination Meeting	Agreement andFollow-Up Plans (RTL)	5 times	5 times	The coordination meeting result report	Directorate of Maternal Health Principal Secretary of Family Planning and Reproductive Health Deputy (Bikup) KSPK (Critiques, Suggestions, Messages, and Impressions) ADPIN (Deputy of Mobilizing Advocacy and Information)	Central Provinces
1.4 to conduct advocacy efforts in a systematic and effective manner to obtain the support and participation of various ministries and government agencies, non-governmental organizations, as well as civil society organizations and donors for KKB program and the implementation of Family Planning Services at different administrative levels.	1.4.1 Developing an effective advocacy strategy to obtain support and participation of various ministries and government institutions, non-government organizations, self-help groups, and donor institutions towards the KKB Program and theimplementors of Family Planning Service at various administrative levels	1.4.1.1Development of the Communication, Information, Education material production message content	Advocacy materials available according to targeted groups					

Key Programs	Sub-Programs	Activities	Indicators	Target		Verification Models	Responsible Units	Implementing Units [The Central, Province, District/Municipality]
				2014	2015			
	1.4.2 Preparing effective advocacy materials to obtain support and participation of various ministries and government institutions, non-government organizations, self-help groups, and donor institutions towards the KKB Program and theimplementors of Family Planning Service at various administrative levels	1.4.2.1 Doing data analysis from various sources as advocacy materials					Litbangkes (Health Research and Development Board) BKKBN Research and Development Unit Universities	
	1.4.3 Conducting effective advocacy to obtain support and participation of various ministries and government institutions, non-government organizations, self-help groups, and donor institutions towards the KKB Program and theimplementors of Family Planning Service at various administrative levels	1.4.3.1 Introducing the Family Planning Service Guidelines in Health Service Facilities for Health Services and Hospitals	All Health Services and Hospitals	1005 in the main pillar areas	100% of all areas which have not been covered	The program activity report	Directorate of Health referral BKKBN	Supervision and Training and Development Department of Central BKKBN
Strategy 2:Increase of availability, affordability, and quality of the Family Planning Service at the grassroot level, including the Communication, Information, Education Service and Counselling								
2.1.to ensure the availability of a wide range of resources in terms of the types, quantity and quality to provide quality family planning services, including Communication, Information, and Education and Counseling services	2.1.1 Planning, providing, and allocating work force with the proper number and qualification to implement the Family Planing Service, including the Communication, Information, and Education service and Counselling	2.1.1.1 The Family Planning Clinic condition analysis (K/O/KB) and the mapping	The Family Planning Clinic condition map formed based on the capacity	1 condition map in 10 main pillarprovinces	1 continous analysis in the areas which have not been covered	K/O/KB data	CentralBKKBN (Department of Family Planning, Ditlaptik [Directorate of Reporting and Statistics], Dittifok [Directorate of Information Technology and Documentation])	Central BKKBN
	2.1.2 Planning and conducting trainings for implementing staff ofthe Family Planing Service, including the Communication, Information, and Education service, in order to ensure the required competence is mastered	2.1.2.1 Making need plans in accordance with the K/O/KB analysis results	The need plans as the support of the 2014-2015 Family Planning program implementation made	1 action plan to increase the Family Planning Service in regions	1 action plan to increase the Family Planning Service in regions accomplished		BKKBN The Ministry of Health Relevant Sectors	

Key Programs	Sub-Programs	Activities	Indicators	Target		Verification Models	Responsible Units	Implementing Units [The Central, Province, District/Municipality]
				2014	2015			
	2.1.3 Planning and providing health service facilities capable of providing the quality Family Planning Service , including the Communication, Information, Education service and Counselling	2.1.3.1 Strengthening the Family Planning service in the free clinic facilities (Community Health Centers, Hospitals)	The number of health service facilities ready to provide the National Social Security System (SJSN) Family Planning (KB) Service	23,500 Health Facilities ready to provide KB-SJSN service		RPJMN Minisurvey and Survey Routine Report	BKKBN Relevant Partners	
		2.1.3.2 Increasing the number/proportion of Family Planning Clinics (government-owned and private) which provide the Family Planning service in accordance with SOP	The percentage of Family Planning Clinics (government-owned and private) which provide the Family Planning service in accordance with SOPthrough the mechanism ofinformed choiceand informed consent	100% of Family Planning Clinics (government-owned and private)		K/O/KB routine report	Ministry of Health BKKBN	
		2.1.3.3 Developing a pooling system for the areas with a small number of acceptor candidates	The acceptor candidates receiving service in the backwarded, remote, and border areas			Routine reports BKKBN Counselling and Supervision Report		
	2.1.4 Planning, providing, and distributing medical equipment with the sufficient type, number, and quality to carry out the Family Planning Service, the Communication, Information, Education Service, and Counselling	2.1.4.1 Fulfilling the facility and infrastructure needs	The number of basic health facilities having the facilities and infrastructure of the Family Planning Service					
			The number of the Family Planning Service facilities distributed toPopulation and Family Planning clinics (BKKBN):	63,139 clinics		K/O/KB		
			The number of reference health facilities having Family Planning Service facilities			K/O/KB		
			Implant Kit					
			VTP Kit					
			Dry sterilisator					
			Laparoscopy witha monitor					
			Laparoscopy withouta monitor					
		2.1.4.2 Fulfilling the facility and infrastructure needs of Family Planning Service	CPR increasing, through the fulfillment of the facilities and infrastructure in health service facilities	63,139 clinics		K/O/KB of Counselling and Supervision of the Family Planning Program	BKKBN	
		2.1.4.3 The making of the book as the contraception devices and drugs logistic guidelines	The book as the contraception devices and drugs logistic guidelines available	1 piece		Counselling and Supervision of the Family Planning Program	Directorate of Maternal Health	
	2.1.5 Planning, providing, and distributing assisting materials and kits with the sufficient types, number, and quality to carry out the Communication, Information, Education Service and Counselling	2.1.5.1 ProvidingKIE (Communication, Information, Education) kits and ABPK (the Decision Making Assisting Kits)	The needs fulfilled through DAK (Special Allocation Funds) and ABPK			Counselling and Supervisionon of the Family Planning Program	BKKBN	
		2.1.5.2 Providing ABPK	The ABPK book available	500 copies so every Community Health Center has the ABPK book.			Directorate of Maternal Health	Ministry of Health
		2.1.5.3 Increasing human resources with technical and medical trainings, Interpersonal Communication (KIP) Counselling, and ABPK	There are human resources to provide Family Planning Counselling.					

Key Programs	Sub-Programs	Activities	Indicators	Target		Verification Models	Responsible Units	Implementing Units [The Central, Province, District/Municipality]
				2014	2015			
	2.1.6 Planning, providing, and distributing contraception devices and drugs with the sufficient types, number, and quality to carry out the Family Planning Service	2.1.6.1 Providing contraception devices and drugs in all health service facilities	The number of health service facilitiesprovidingcontraception devices and drugs	23,500 registered health facilities		F/V/KB K/O/KN	BKKBN	Central Provinces
			The handling cost available for the distribution of contraception devices and drugs to all the Family Planning service centers	In every provincial BKKBNhandling cost is available.		Technical guidance of handling cost available	BKKBN	Provincial BKKBN District/Municipality Regional Apparatus Work Unit (SKPD)
			USER (PA) (in 7 special provinces all couples of reproductive age are funded)					
			IUD					
			MOP (Male Surgery Method)					
			MOW (Female Surgery Method)					
			IMPLANT					
			INJECTION					
			PILLS					
			CONDOMS					
		2.1.6.2 Optimalization of the role of the Contraception Availability Security Team (CAS Team) in the mechanism of the dynamic contraception devices and drugs distributionamong health facilities in Districts/Cities	The non-stock not happening in health service facilities through the duties, main responsibilities, and functions of the CAS Team In all provinces there are CAS Teams. In 5 Districts/Cities in every province there are CAS Teams.	33 provinces		Provincial Letter of Decision Regent/Municipal Letter of Decision	BKKBN	
		2.1.6.3 Providing freecontraception devices and drugs for all couples of reproductive age	Contraception devices and drugs for couples of reproductive ageavailable					
		2.1.6.4 Setting and testing thesupply chain systemof contraception devices and drugs	The testing of thesupply chain systemof contraception devices and drugs conducted	4 regencies which have already had BKKBD			BKKBN	
	2.1.7 Planning and conducting efforts to control the quality of Family Planning Service at various administrative levels	2.1.7.1 Forming the Quality Maintaining Team (QMT) at thecentral, provincial, and regency/municipal levels	The Quality Maintaining Team formed at the provincial level and minimal in 1 regency/town of every province	33 provinces 1 regency/town in everyprovince			BKKBN	
		2.1.7.2 Conducting the surveillance intensification post the service	The surveillance post the service conducted	33 provinces (497 Districts/Cities)			BKKBN	
		2.1.7.3 Monitoring and Evaluation Post the Family Planning and Woman Empowerment trainings	Participants of the Family Planning and Woman Empowerment trainingswho provide service of Family Planning and Woman Empowerment in their work place	5 Districts/Citiesin 3 provinces			Directorate of Maternal Health	
		2.1.7.4 Orientation of Family Planning recording and reporting	The number of health service facilitiesconducting recording and reporting(Family Planning Cohorts)	All Community Health Centers			Directorate of Maternal Health	

Key Programs	Sub-Programs	Activities	Indicators	Target		Verification Models	Responsible Units	Implementing Units [The Central, Province, District/Municipality]
				2014	2015			
2.2. to ensure that the whole population can afford and obtain family planning services they need including Communication, Information, and Education and Counseling services	2.2.1Carrying out Family Planning Service, including Communication, Information, Education service and Counselling, in healthservice facilitiesaccessible and reachable by community	2.2.1.1 ANC service including Family Planning service counselling	Coverage ofC1 andC4	C1:95% C4: 90%	C1:95% C4: 90%		Ministry of Health	Ministry of Health, Provincial Health Office, District/Municipal Health Office
	2.2.2 Conductingoutreach services to reach the population who cannot easily access health service facilities which carry out Family Planning Service, including Communication, Information, Education service and Counselling	2.2.2.1 Special area Family Planning service activities and through momentum activities	The Family Planning activities carried out in the backwarded, remote, border areas, urban ghetto, company Family Planning			F/II/KB Minisurvey Survey RPJMN		
	2.2.3 Conducting Family Planning Service, including Communication, Information, Education service and Counselling, with affordable prices by community's purchasing power	2.2.3.1 Acceptor activation and counselling in the field through the field Family Planning officers	Family Planning service carried out through static service and special areas			F/II/KB Minisurvey SurveyRPJMN		
	2.2.4 Providing financing security for poor community to obtain Family Planning Service, including Communication, Information, Education service and Counselling	2.2.4.1 Family Planning service in the National Health Security (JKN)	Maternity mothers who get PBI (Funding Receiving Board) in JKN obtaining Family Planning Service	60%	65%			
Strategy 3: Increase of the Family Planning Service request through value change on the ideal number of children in a family								
3.1 Conducting Communication, Information, Education service and Counselling systematically, effectively, and in good quality to plant the value of "enough having 2 children", increase the understanding on the importance of preventing "4 too many children", and accept the use of contraception	3.1.1 Developing and introducing the strategy and the method ofCommunication, Information, Education service systematically and effectively to plant the value of "enough having 2 children", increase the understanding on the importance of preventing "4 too many children", and accept the use of contraception	3.1.1.1 Increasing the implementation of face-to-face Family Planning Communication, Information, Education, and the acceptor activation and counselling in the field through the field Family Planning officers	CPR 60.1%			F/II/KB Minisurvey SurveyRPJMN		

Key Programs	Sub-Programs	Activities	Indicators	Target		Verification Models	Responsible Units	Implementing Units [The Central, Province, District/Municipality]
				2014	2015			
	3.1.2 Developing, providing, and distributing effective assisting tools for Communication, Information, Education serviceto plant the value of "enough having 2 children", increase the understanding on the importance of preventing "4 too many children", and accept the use of contraception	3.1.2.1 Increasing the implementation of face-to-face Family Planning Communication, Information, Education, and the acceptor activation and counselling in the field through the field Family Planning officers				F/II/KB Minisurvey SurveyRPJMN		
	3.1.3 Developing the understanding on pregnancy health, giving birth, period of 40 days after giving birth, Family Planning, and pregnancy complication and its prevention via the role empowerment of midwives, candidates, and community	3.1.3.1 Carrying out Pregnant Mother Classes					Ministry of Health	Health Service Midwives Candidates
		3.1.3.2 Increasing the understanding on the importance of ANC, the counselling of reproductive health for pregnant mothers, and Familly planning after giving birth	The counselling of ANC, reproductive health, and Family Planning after giving birth carried out	80%	100%		Ministry of Health BKKBN	Central Provinces District/cities
		3.1.3.3Development of reproductive health promotion and counselling via reproductive health Communication, Information, Education materials	Reproductive health promotion and counselling materials available in health facilities	23,500 clinic			Ministry of Health BKKBN	Central Provinces Districts/Cities
		3.1.3.4. P4K (Maternity Planning and Complication Prevention Program)	Villages carrying out P4K				Ministry of Health	Health Office Midwives Cadres
		3.1.3.5 PKRE (Essential Reproductive Health Package)	The number of regencies having minimal 4 Community Health Centers capable of PKRET (Integrated Essential Reproductive Health Service)	100%	100%	Routine reports	Directorate General in charge of Mothers' Health	
3.2 to involve community, traditional and religious leaders in instilling the values of "two children is enough" and 4 "too's" prevention and in encouraging acceptance of the use of contraceptives	3.2.1 Doing the Communication, Information, Educationactivities for the relevant stakeholders and public figures systematically and effectively to plant the value of "enough having 2 children", increase the understanding on the importance of preventing "4 too many children", and accept the use of contraception	3.2.1.1Increasing the implementation of face-to-face Family Planning Communication, Information, Education, and the acceptor activation and counselling in the field through the field Family Planning officers				F/II/KB Minisurvey Survey RPJMN		

Key Programs	Sub-Programs	Activities	Indicators	Target		Verification Models	Responsible Units	Implementing Units [The Central, Province, District/Municipality]
				2014	2015			
	3.2.2 Together with the relevant stakeholders and public figures carrying out Communication, Information, Education service systematically and effectively to plant the value of "enough having 2 children", increase the understanding on the importance of preventing "4 too many children", and accept the use of contraception	3.2.2.1 Increasing the implementation of face-to-face Family Planning Communication, Information, Education, and the acceptor activation and counselling in the field through the field Family Planning officers				F/II/KB Minisurvey SurveyRPJMN		
	3.2.3 Preparing the field for the activation of acceptor candidates and PA (acceptor counsellors)	3.2.3.1 Providingthe map of couples of reproductive age	The map of couples of reproductive age available in every hamlet					
		3.2.3.2 Activate face-to-face Communication, Information, Education, and counselling	Face-to-face Communication, Information, Educationthrough farmer groups					
	3.2.4 Counselling new Family Planning participants and PA (repeated)	3.2.4.1 Spreading information via various media	Communication, Information, Educationcarried out via electronic media, printed media, and traditional media					
		3.2.4.2 Increasing support for the field Family Planning activation	Operational costs for Family Planning acceptor activation available					
	3.2.5 Observation and reporting	3.2.5.1 Developing the contraception service reporting system	Data and information of contraception devices and drugs available through routine reports, reviews, and supervision					
		3.2.5.2 Developing the Logistic Management Information System (LMIS)	The Logistic Management Information System (LMIS) available					
3.3 to increase the participation of men in family planning.	3.3.1 Increasing promotion and Communication, Information, Educationon male participation increase in the Family Planning Program	3.3.1.1Developing the promotion and Communication, Information, Educationmaterials on male participation (including condom promotion as dual protection)in the Family Planning Programwith the message content development according to local culture	The promotion and Communication, Information, Educationmaterialson effective male participation increase in the Family Planning Programavailable	Male Family Planning participation becoming 2.9%	Male Family Planning participation becoming 3%	F/II/KB Minisurvey Survey RPJMN	BKKBN Ministry of Health	Ditjalsus (Directorate in charge of Family Planning Participation for Special Areas and Targets) Directorate General in charge of Mothers' Health Ministry of Health Biro KURAIS (KURAIS Office) Ministry of Religious Affair MUI (Indonesian Ulama Council) Board of Indonesian Mosques FAPSEDU (Forum for Religious Followers Caring for Prosperous Family and Population) FamilyPlanning DepartmentProvincial BKKBN Provincial Health Office District/Municipal Family Planning Regional Apparatus Work Unit District/Municipal Health Office

Key Programs	Sub-Programs	Activities	Indicators	Target		Verification Models	Responsible Units	Implementing Units [The Central, Province, District/Municipality]
				2014	2015			
	3.3.1. Increasing promotion and Communication, Information, Educationon male participation increase in the Family Planning Program	3.3.1.1. Developing the promotion and Communication, Information, Educationmaterials on male participation (including condom promotion as dual protection)in the Family Planning Programwith the message content development according to local culture	The advocacy materials on the male participation increase in the Family Planning Programavailable for public figures, religious figures, and the stakeholders	Male Family Planning participation becoming 2.9%	Male Family Planning participation becoming 3%	F/II/KB Minisurvey Survey RPJMN	BKKBN The Ministry of Health	Ditjalsus Directorate of Maternal Health Ministry of Health Biro KURAIS (KURAIS Office) Ministry of Religion MUI (Indonesian Ulema Council) Board of Indonesian Mosques FAPSEDU FamilyPlanning DepartmentProvincial BKKBN Provincial Health Office District/Municipal Family Planning SKPD (Regional Apparatus Work Unit) District/Municipal Health Service
	3.3.2 Increasing the access and quality of male vasectomy Family Planning service	3.3.2.1Developing the comprehensive reference system for male vasectomy Family Planning service	The comprehensive reference system for male vasectomy Family Planning service available in every regency/town	50% providers in Districts/Cities in 10 main pillarprovincescapable of providing male vasectomy Family Planning service in good quality	100% providers in Districts/Cities in 10 main pillarprovincescapable of providing male vasectomy Family Planning service in good quality	F/II/KB Minisurvey Survey RPJMN	BKKBN The Ministry of Health	Ditjalsus Ditjalpem (Directorate in charge of Family Planning Participation via Government) Dir. BUK (Directorate General in charge of Health Efforts) IAUI (Indonesian Urologist Association) PKMI (Indonesian Community Health Development) District/Municipal Health Office
	3.2.3 Increasing the access of male Family Planning service financing	3.2.3.1Developing the effective vasectomy male Family Planning service financing system	The effective vasectomy male Family Planning service financing system available in every regency/town in 10 main pillar provinces	75% providers giving vasectomy male Family Planning service in Districts/Cities in 10 main pillar provincesbecoming the Health BPJS (Social Security Executing Board) network	100% providers giving vasectomy male Family Planning service in Districts/Cities in 10 main pillar provincesbecoming the Health BPJS network	F/II/KB Minisurvey Survey RPJMN	BKKBN The Ministry of Health	Ditjalsus Ditjapem Directorate of P2JK (Health Financing and Security Center) Ministry of Health Health BPJS Provincial BKKBN District/Municipal Family Planning SKPD District/Municipal Government
Strategy 4: The decrease of unmet need through the increase of Family Planning access, counselling, and strengthening post giving birth as well as the decreaseof contraception use continuity through the increase of MKJP (Long-Term Contraception Method) use and Family Planning counselling								
4.1. to prevent the occurrence of unmet need and increase the use of MKJP through improved knowledge about rational selection of contraceptive methods	4.1.1 Developing the counselling service method to increase the knowledge of acceptor candidates/ acceptors on choosing the rational contraception method	4.1.1.1 Activating the function of Field Officers/Candidates as simple counsellors.The effort to increase the role ofmidwives as counsellors.						
		4.1.1.2 Increase of Family Planning service post giving birth and post miscarriage	The number of health facilities which carry out Family Planning service post giving birth and post miscarriage	23,500 Family Planning Clinics	All health facilities which have been registered	F/II/KB Minisurvey Survey RPJMN Routine reports		

Key Programs	Sub-Programs	Activities	Indicators	Target		Verification Models	Responsible Units	Implementing Units [The Central, Province, District/Municipality]
				2014	2015			
	4.1.2 Developing, providing, and distributing counselling service assisting devices to increase the knowledge of acceptor candidates/ acceptors on choosing the rational contraception method.	4.1.2.1 Providing counselling materials	The number of curricula and learning material modules for doctors,midwives, field officers			F/II/KB Minisurvey Survey RPJMN		
		4.1.2.2 Developing simple counselling materials for Family Planning field officers (non-medical officers)	The number of curricula and learning material modules for doctors,midwives, field officers			F/II/KB Minisurvey SurveyRPJMN		
	4.1.3 Reorientation of the importance of MKJP and Family Planning post giving birth	4.1.3.1 Producing materials of KIE KB-MKJP (Family Planing Communication, Information, Education-MKJP)	Various materials of KIE KB-MKJP available			F/II/KB Minisurvey SurveyRPJMN Counselling andSupervision		
		4.1.3.2 Developing simple Communication, Information, Education materials for Family Planning field officers (non-medical officers)	Various materials of KIE KB-MKJP available			F/II/KB Minisurvey SurveyRPJMN Counselling andSupervision		
		4.1.3.3 Producing materials of KB-MKJP Counselling	The materials of KB-MKJP Counselling available			F/II/KB Minisurvey SurveyRPJMN Counselling andSupervision		
		4.1.3.4 Developing simple counselling materials for Family Planning field officers (non-medical officers)	The materials of KB-MKJP Counselling available			F/II/KB Minisurvey SurveyRPJMN Counselling andSupervision		

Key Programs	Sub-Programs	Activities	Indicators	Target		Verification Models	Responsible Units	Implementing Units [The Central, Province, District/Municipality]
				2014	2015			
	4.1.4 Increasing the counselling capability on the advantages of contraception devices and drugs, particularly IUD and implant	4.1.4.1 Increasingthe officer capacityin counselling throughE-learning TOT fordoctorsormidwives	The number ofdoctors ormidwiveswho have takenE-learning TOT					
		4.1.4.2 Increasingthe officer capacityin counselling throughE-learning TOTfor counsellors	The number ofcounsellorswho have takenE-learning TOT					
		4.1.4.3 Conducting e-learning trainings	The number ofparticipants who have taken e-learning trainings					
		4.1.4.4 Increasingthe counselling capability ofdoctors	The number ofdoctorswho have their counselling capability improved					
		4.1.4.5 Increasingthe counselling capability ofmidwives	The number ofmidwiveswho have their counselling capability improved					
		4.1.4.6 Increasingthe counselling capability ofPLKB (Family Planning Field Officers)	The number of PLKB who have their counselling capability improved					
		4.1.4.7 Increasingthe counselling capability ofPPKBD (Village Family Planning Counsellor Assistants)	The number of PPKBD who have their counselling capability improved					
		4.1.4.8 Increasingthe counselling capability ofSub-PPKBD	The number of Sub-PPKBD who have their counselling capability improved					
		4.1.4.9 Increasingthe counselling capability ofPKK (Family Welfare Program) Candidates	The number of PKK Candidates who have their counselling capability improved					
		4.1.4.10 Technical assistance sharing experiences	The number ofFamily Planning Service managing staff updated with international tehnology					
			The number of experts meeting on theKKBprogramin Indonesia					
	4.1.5 Conducting counselling in order to increase the knowledge of acceptor candidates/ acceptors on choosing the rational contraception method.							

Key Programs	Sub-Programs	Activities	Indicators	Target		Verification Models	Responsible Units	Implementing Units [The Central, Province, District/Municipality]
				2014	2015			
4.2 to lower the incidence of side effects through the provision of quality family planning services and to ensure side effects are dealt with promptly and appropriately.	4.2.1 Increasing the skills of health work force in providing Family Planning Service	4.2.1.1 Carrying out CTU (Contraception Technology Update) trainings fordoctors	The number ofCTU-trained doctors					
		4.2.1.2 Carrying out MOP (Male Surgery Method) trainings fordoctors	The number ofMOP-trained doctors					
		4.2.1.3 Carrying out MOW (Female Surgery Method) trainings fordoctors	The number ofMOW-trained doctors					
		4.2.1.4 Carrying out CTU trainings formidwives	The number ofCTU-trained midwives					
		4.2.1.5 Carrying out KIP/K (Interpersonal Communication/Counselling) trainings formidwives	The number ofKIP/K-trained midwives					
		4.2.1.5 Trainings of Family Planning post Giving Birth for Health Facilities	Health facilities which have been trainedKBPP	1,514 Health facilities(2838 health facilities in total)		The training result reports	Ministry of Health	Ministry of Health Health Offices BKKBN
		4.2.1.6 Carrying out CTU trainings fordoctors and midwives					BKKBN	
		4.2.1.7 Carrying out ABPK (Decision Making Assisting Kits) trainings for midwivesand candidates					BKKBN	
		4.2.1.8 Carrying out trainings for CTU and KIP/K Trainers	Forming CTU and KIP/K Trainer Teams at the provincial level	Teams formed in 33 provinces			Ministry of Health BKKBN	PP IBI (Profession Education of Indonesian Midwife Association)
		4.2.1.9 Carrying out CTU and KIP/K trainings for BPM (Independent Practising Midwives)	The number ofCTU and KIP/K-trained BPMs		10% (3500) out of registered BPM		Ministry of Health BKKBN	PP IBI
		4.2.1.10 Carrying out BPM recruitment to become DelimaMidwives	The number of BPMs who become Delima Midwives	1200	1350		Ministry of Health BKKBN	Delima Midwife Executing Unit of PP IBI
	4.2.2 Increasing the capability of trainers in providing Family Planning Service trainings	4.2.2.1 Carrying out technical and medical TOT fordoctors	The number oftechnical and medicaltrainersfordoctors					
		4.2.2.2 Carrying out technical and medical TOT trainings formidwives	The number oftechnical and medicaltrainersformidwives					
	4.2.3 Increasing the capability of educating staff in providing Family Planning Service education	4.2.3.1 Carrying out trainings to increase the capacity of educating staff in Family Planning service	The number ofeducation staff whose capability has been improved in providing Family Planning service education					

Key Programs	Sub-Programs	Activities	Indicators	Target		Verification Models	Responsible Units	Implementing Units [The Central, Province, District/Municipality]
				2014	2015			
	4.2.4 Assuring the quality of Family Planning Service	4.2.4.1 Increasing the implementation of fasilitation supervision	The number ofCommunity Health Centerswhich implement fasilitation supervision	497	497	UKP4 Reports	Directorate of Maternal Health	District/Municipal Health Office
		4.2.4.2 Setting instruments of Family Planning Monitoring and Evaluation in Hospitals					Directorate of Health referral	
		4.2.4.3 Implementation of the Midwife Education Standard and Guideline in hospitals, Community Health Centers,midwives in villages and BPM	The number ofhospitals and Community Health Centers which apply the midwife education standard and guideline	640 Community Health Centers 122 Hospitals	700 Community Health Centers 135 Hospitals	Routine Reports	Directorate in charge of Midwife Service and Medical Engineering	Ministry of Health Provincial Health Office District/Municipal Health Office
	4.2.5 Consolidating KB MKJP Midwife education (IUD and Family Planning susuk/ some kind of implant) in hospitals andCommunity Health Centers	4.2.5.1 Conducting meetings with various stakeholders in the regency/ municipal levels, coordinators of midwives,midwives working in the field, and Independent Practising Midwives	Meetings with stakeholders conducted	40 times of meetings	40 times of meetings	Activity Reports	Sub Directorate in charge of MidwivesDirectorate General in charge of Midwife Serviceand Medical Engineering	Ministry of Health
		4.2.5.2 Consolidating the use of MKJP through midwife education integrated with PMK (Health Problem Handling) in Mother and Child Health service in hospitals, Community Centers, and their network	The number ofhospitals and Community Health Centers which apply Family Planning education	640 Community Health Centers 122 Hospitals	700 Community Health Centers 135 Hospitals	Routine Reports	Sub Directorate General in charge of MidwivesDirectorate General in charge of Midwife Serviceand Medical Engineering	Ministry of Health Provincial Health Office District/Municipal Health Office
4.3 to ensure compliance of users with standard use of contraceptives through quality counseling services	4.3.1 Developing the counselling service method to increase the obedience of the acceptor candidates/ acceptors towards the contraception use standard.							
	4.3.2 Developing, providing, and distributing counselling service assisting devices to increase the obedience of acceptor candidates/ acceptors towards the contraception use standard.							
	4.3.3 Carrying out counselling in order to increase the obedience of acceptor candidates/ acceptors towards the contraception use standard.	4.3.3.1 Carrying out Family Planning service for all counselling-based methods	The number ofactive and new acceptors served by PKBI (Indonesian Family Planning Association) clinics all over Indonesia			Service result reports	The managing unit of the Central PKBI dealing with the operational guideline onHepatorenal Syndrome (HRS) and HIV-AIDS	22 regional/provincial PKBIsand 9 regency/municipal branch PKBIs
	4.3.4 Providing protection for contraception failure	4.3.4.1 Providing counselling-based service of unwanted pregnancy	The number ofparticipants getting the service			Service result reports	The managing unit of the Central PKBI dealing with the operational guideline onHepatorenal Syndrome (HRS) and HIV-AIDS	12 clinics inregional/provincial PKBIsand 3 clinics inregency/ municipal branch PKBIs

Key Programs	Sub-Programs	Activities	Indicators	Target		Verification Models	Responsible Units	Implementing Units [The Central, Province, District/Municipality]
				2014	2015			
Strategy 5: Decrease of the number of pregnant teenagers age 15 to 19 years old through the increase of the age for getting married and the increase of knowledge on Adolescence Reproductive Health								
5.1 to increase the range and quality of IEC and counseling services for adolescents to improve their knowledge, attitude and behavior related to reproductive health and family planning	5.1.1 Developing thestrategyand method of systematic and effective Communication, Information, Education service and Counselling to improve the knowledge, attitude, and behavior of teenagersrelated to Reproductive Health and Family Planning.	5.1.1.1 Implementing PKPR (Health Service for Teenagers)	Percentage of Districts/Citieswith Community Health Centers capable of PKPR	90% of Districts/Cities	92% of Districts/Cities	Routine reports	Directorate of Child Health	Provincial Health Office District/Municipal Health Office
			The number ofelementary schoolsimplementing UKS (Health Efforts in School) networking	95% ofelementary schools		Routine reports	Directorate of Child Health	Provincial Health Office District/Municipal Health Office
	5.1.2 Developing, providing, and distributing assisting devices for Communication, Information, Education service and Counselling to improve the knowledge, attitude, and behavior of teenagersrelated to Reproductive Health and Family Planning.	5.1.2.1 Activities of Youth Centers	The number and type of media of Communication, Information, Education produced			Service report results	managing unit of the Central PKBI dealing with the operational guideline onAdolescence	24 Youth Centersin 24 provinces
		5.1.2.2 Development of Communication, Information, Education materials and facilities for field officers				F/II/KB Minisurvey Survey RPJMN Counselling andSupervision		
	5.1.3 Together with relevant stakeholders and public figures carrying out Communication, Information, Education service and Counselling to improve the knowledge, attitude, and behavior of teenagersrelated to Reproductive Health and Family Planning.	5.1.3.1 Communication, Information, Education activitiesof Youth Centers	The number ofCommunication, Information, Education activity participants			Service report results	managing unit of the Central PKBI dealing with the operational guideline onAdolescence	24 Youth Centersin 24 provinces
		5.1.3.2 Development of Communication, Information, Education materials and facilities for field officers. Strengthening the Family Planning participation counselling forums and reproductive health education through partnership				F/II/KB Minisurvey Survey RPJMN Counselling andSupervision		
	5.1.4 Increasing the adolescence role in improving the knowledge, attitude, and behavior of teenagersrelated to Reproductive Health and Family Planning.	5.1.4.1 Providing contraception service to the teenagers who have been sexually active	The number ofteenagers getting contraception service			Service report results	managing unit of the Central PKBI dealing with the operational guideline onAdolescence	4 Youth Centers (Jabar [West Java], Bali, Sulut [North Sulawesi], DIY [Yogyakarta Special Region])
		5.1.4.2 Development of Communication, Information, Education materials and facilities for field officers. Strengthening the Family Planning participation counselling forums and reproductive health education through partnership				F/II/KB Minisurvey Survey RPJMN Counselling andSupervision		

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